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# **RESTRICTIVE TRADE PRACTICES COMMISSION**

HEARINGS RELATED TO THE MANUFACTURE, DISTRIBUTION  
AND SALE OF DRUGS

## **HEARINGS**

*HELD AT*

**HALIFAX, N.S.**

AND

**WINNIPEG, MAN.**

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VOLUME 4-7

JULY 10, 11 and 17, 1961

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Professor H.J. Fuller





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INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the Manufacture, Distribution and Sale  
of Drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	-	Chairman
A.S. WHITELEY, M.A.	-	Member of the Commission
PIERRE CARIGNAN, Q.C.	-	Member of the Commission
F.N. MAC LEOD	-	Combines Officer, representing the Director of Investigation and Research.

HEARINGS HELD AT HALIFAX, NOVA SCOTIA, on July 10th,  
1961.



1 THE CHAIRMAN: Ladies and  
2 gentlemen, I think you all know that this is an  
3 inquiry into the manufacture, distribution and  
4 sale of drugs being conducted now by the  
5 Restrictive Trade Practices Commission. We  
6 opened public hearings in Ottawa last week and  
7 are now commencing in Halifax.  
8

9 We hope to receive considerable  
10 information from people in this part of the  
11 Country which will be helpful in ascertaining  
12 what the facts are in various phases of the drug  
13 industry.

14 To begin with this morning I  
15 would like to know who are appearing and whom  
16 they represent and we will try and see what ar-  
17 rangements can be made which will be most con-  
18 venient for the time at which their represent-  
19 ations and briefs will be made.

20  
21 Mr. MacLeod is appearing for the  
22 Commission and will ask questions. He is working  
23 with the Commission. We would like to know who  
24 are appearing this morning, who are here and  
25 what organization they represent and then we will  
26 try and adjust our timetable to suit your conven-  
27 ience as much as possible. I believe we have  
28 the Trades and Labour Council.

29 MR. BELL: My name is Bell, J.K.  
30 Bell. I represent the Halifax-Dartmouth and





1 District Labour Council, the Labour Council of  
2 Halifax. I am accompanied by Mr. Gordon A. Smith  
3 and Mr. George A. Smith. Mr. Gordon A. Smith is  
4 also with the Labour Council and Mr. George A.  
5 Smith is a representative of the Canadian Labour  
6 Congress in this area. We have a very short brief,  
7 Mr. Chairman.  
8

9 THE CHAIRMAN: Who else, do you  
10 know Mr. MacLeod? Who are the others?

11 MR. MAC LEOD: Dr. G.H. Reardon.  
12 Dr. Reardon was asked to appear at ten o'clock,  
13 stating a definite time because of the demands of  
14 his practice, as a busy practitioner and Dr. D.J.  
15 W. Reid was asked to come at ten-thirty. I don't  
16 know Dr. Reid personally. I don't know whether he  
17 is here.

18 THE CHAIRMAN: How do you spell  
19 Reid?

20 MR. MAC LEOD: R e i d . Then  
21 there is a representation from the Hospital  
22 Insurance Commission of Nova Scotia here, Mr.  
23 Kennedy, and Dr. Clyde Marshall of the Department  
24 of Public Health of Nova Scotia. Mr. William  
25 Cox, a solicitor here is representing the Nova  
26 Scotia Pharmaceutical Association. Perhaps he  
27 can tell you himself what time would be conven-  
28 ient for him.  
29

30 MR. COX: Mr. Chairman, I



1 represent the Nova Scotia Pharmaceutical Society.  
2 I have with me today Mr. Keith Lawton and Mr.  
3 Edwin Cook of the Society. I spoke to Mr.  
4 MacLeod yesterday concerning the brief which the  
5 Society has prepared and it would be convenient  
6 for the Society if it meets the Commission's  
7 convenience that we be allowed to reserve our  
8 right to present that brief tomorrow because it  
9 is not completed at the present time.

10 THE CHAIRMAN: You are Mr. Cox.

11 I think we will have Dr. Reardon ap-  
12 pear first as it is definitely arranged that Dr.  
13 Reardon would be here at ten o'clock. It would  
14 probably a serious inconvenience to him to have to  
15 come back again having made arrangements to clear  
16 himself for this time. Is Dr. Reid to be at 11  
17 o'clock?

18 MR. MAC LEOD: Ten-thirty.

19 THE CHAIRMAN: Ten-thirty.  
20 The Hospital Insurance Commission?

21 MR. MAC LEOD: The representative  
22 was told at eleven o'clock. He is here now and,  
23 presumably, if some of the other witnesses are  
24 finished early, I presume we could go ahead.

25 THE CHAIRMAN: And Dr. Marshall?

26 MR. MAC LEOD: No time was assigned  
27 to Dr. Marshall.

28 THE CHAIRMAN: Now, Mr. Bell, is it  
29 important to you that you be heard this morning?





1  
2 MR. BELL: We have a very short sub-  
3 mission, Mr. Chairman. I am sure ours could be  
4 quickly and easily disposed of. We have just a  
5 few general observations on the situation.

6 THE CHAIRMAN: What do you mean by  
7 quickly?

8 MR. BELL: Pardon?

9 THE CHAIRMAN: Ten minutes?

10 MR. BELL: We have a three or four  
11 page brief and some general observations. It  
12 would depend on the questions.

13 THE CHAIRMAN: Your brief won't take  
14 more than ten or fifteen minutes and there may be  
15 some questions. It may be possible to have you  
16 this morning. We must put Dr. Reardon and Dr. Reid  
17 on first. I think that is clear. Is Dr. Marshall  
18 here?

19 MR. MAC LEOD: Yes.


20 THE CHAIRMAN: Dr. Marshall, we  
21 set no definite time for you.

22 DR. MARSHALL: No.

23 THE CHAIRMAN: It looks to be very  
24 difficult to get you in this morning.

25 DR. MARSHALL: That would be most  
26 convenient.

27 THE CHAIRMAN: It looks to be very  
28 difficult to do that.  
29  
30



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1  
2 DR. C.H. REARDON, sworn

3  
4 MR. MAC LEOD: What is your full  
5 name?

6 DR. REARDON: Charles Henry Reardon.

7 MR. MAC LEOD: You are a medical  
8 doctor practising in the City of Halifax?

9 DR. REARDON: I am.

10 MR. MAC LEOD: You are also a member  
11 of the Legislative Assembly, are you not?

12 DR. REARDON: Yes.

13 MR. MAC LEOD: Are you in general  
14 practice, Doctor?

15 DR. REARDON: Yes.

16 MR. MAC LEOD: In the course of your  
17 practice do you find that anti-biotics are important  
18 drugs?

19 DR. REARDON: Well, I think that is  
20 a statement of fact.

21 MR. MAC LEOD: They are quite  
22 important?

23 DR. REARDON: Certainly they are.

24 MR. MAC LEOD: What about  
25 tranquilizers, a group generally referred to as  
26 tranquilizers?

27 DR. REARDON: I think they are  
28 generally accepted as being important drugs today  
29  
30



1 for many conditions with general practitioners as  
2 well as the other branches, other doctors, medical  
3 specialists and psychiatrists do have occasion to  
4 use them.

5  
6 MR. MAC LEOD: Are they fairly  
7 important in your own practice?

8 DR. REARDON: Oh, yes.

9 MR. MAC LEOD: Doctor, in your  
10 practice do you have any problem arising out of  
11 the number of new drugs that come on the market?

12 DR. REARDON: I have no problem.

13 MR. MAC LEOD: Are you able to keep  
14 yourself up to date on them?

15 DR. REARDON: Yes.

16 MR. MAC LEOD: What sources of in-  
17 formation do you rely on for information about new  
18 drugs?

19 DR. REARDON: Well, I think mainly  
20 doctors rely upon medical journals for their main  
21 sources of information, and another very valuable  
22 source of information comes from the drug Companies  
23 themselves through the media of detail men, through  
24 the media of advertising.

25  
26 MR. MAC LEOD: Now, taking the  
27 medical journals, Doctor, do you find that there is  
28 any time lag there, that you may have to wait a  
29 while to get an authoritative article on new drugs  
30





1 in medical journals or anything like that?

2  
3 DR. REARDON: The time lag is not  
4 so important. You generally can pick up any in-  
5 formation that you really want on new drugs just by  
6 enquiring in the proper place. You can enquire of  
7 your medical school and of your specialist confreres  
8 who know, perhaps a little ahead of you some of  
9 these things. I don't believe that the time lag in  
10 new drugs is really a very important item in general  
11 practice.

12 MR. MAC LEOD: Just referring to  
13 what you said a moment ago, do you feel you are in  
14 a better position being located in Halifax where  
15 there is a medical school and a number of specialists,  
16 do you feel that you have a more adequate source of  
17 information being located in Halifax than you might  
18 have if located elsewhere?

19 DR. REARDON: No, it may be a little  
20 more convenient for me to obtain the information,  
21 but certainly any doctor practising in Nova Scotia  
22 can get information by picking up the telephone and  
23 calling one of his friends in Halifax, one of his  
24 confreres somewhere else. I don't think that is so  
25 important.  
26

27 MR. MAC LEOD: So that you feel that  
28 you have adequate knowledge and sources of knowledge  
29 to use all the new drugs to the best advantage?  
30



1  
2 DR. REARDON: Adequate sources of  
3 knowledge, and they are there if anyone wants to  
4 get them.

5 MR. MAC LEOD: You mentioned a  
6 moment ago the work of the drug Companies.

7 DR. REARDON: Yes.

8 MR. MAC LEOD: Perhaps you will tell  
9 us something about that, the work of the detail men  
10 and the literature which they send to you?

11 DR. REARDON: Well, I think it is  
12 common knowledge to the Commission who have been  
13 hearing all across Canada of the detail men who  
14 visit the Doctor and do outline in detail the new  
15 drugs of that particular Company. I consider this  
16 is a very valuable source of information.

17  
18 There has been some suggestion from  
19 reading through the material here in this green  
20 book that the detail men are trying to press the  
21 doctors the advantages of their drugs ahead of  
22 anybody else. I don't think in my experience that  
23 has been done. I find that the detail men are not  
24 the aggressive group of drug salesmen that you get  
25 the impression they are by reading the paper.  
26 They are a group of men, I find, that try to  
27 disseminate the information they have which might  
28 not be -- I think that it is of benefit to the  
29 doctors and to the benefit of their patients that  
30 these detail men do come through and give





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information as they are doing.

MR. MAC LEOD: Do you think some detail men are more qualified than others and are more useful to you?

DR. REARDON: Well, I suppose that statement would apply to anybody in the profession, whether lawyer, doctor or whatever he is. There is always some more qualified than others. The same would apply to detail men.

MR. MAC LEOD: A doctor testifying in Ottawa gave evidence something to this effect, he found some detail men particularly well qualified and he always made it a point of seeing these men because they had something to contribute to him and certainly other detail men he didn't consider made any contribution at all. He rather sloughed them off.

DR. REARDON: I see them all and they all have something to contribute. I might agree more with one than the other. I think you have to discriminate, decide you agree with them, whether they have anything of value. I don't believe in the fifteen, sixteen years I have been practising I have bumped into any detail men who didn't do some good and didn't give some information that was of some help to me and my patients.



Reardon  
ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO (MacLeod)

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MR. MAC LEOD: Your experience, then,  
is that detail men do give you valuable information?

DR. REARDON: Yes.

MR. MAC LEOD: What about the liter-  
ature that you receive from the drug manufacturers  
and drug distributors?

DR. REARDON: I think about 90% of  
it that you receive in the mail finds its way into  
the waste basket without even being opened.

MR. MAC LEOD: Why should that be?

DR. REARDON: The same literature  
that you receive in the mail, you can receive  
from your medical journals and the advertising in  
the journals -- I would presume that there is more  
selectivity about the advertising in the medical  
journals and I would read them.

MR. MAC LEOD: So that your exper-  
ience is that the material that comes to you  
through the mail from the drug manufacturers and  
the distributors, is that more valuable to you?

DR. REARDON: The bulk of it is  
not. Let us put it this way, the bulk of it is  
not read.

MR. MAC LEOD: The bulk of it is not  
read?

DR. REARDON: That is right.

MR. MAC LEOD: And are there any



1 particular Companies that because of your exper-  
2 ience with their material you look upon their  
3 material as being extremely valuable, or anything  
4 like that?

5 DR. REARDON: I think the Canadian  
6 Drug Companies pretty well without question -- and  
7 I am speaking now of the drug Companies that have  
8 been here for years -- which are large Companies  
9 and you learn to respect them over the years.

10 MR. MAC LEOD: Yes?

11 DR. REARDON: I think they are all  
12 of value.

13 MR. MAC LEOD: I was wondering if  
14 there were, if this might be possibly the situation  
15 that if you see something from X Company that you  
16 would have a tendency to put that aside and perhaps  
17 make an effort to read it because you would regard  
18 X Company's information as being particularly care-  
19 fully prepared, or is there anything like that?

20 DR. REARDON: I think that in the  
21 first place I have made the statement that we  
22 pitch out 90 percent without even looking at it.  
23 Therefore the ones that might catch my eye, that I  
24 do look at, they are all from pretty reliable  
25 Companies and I think some of the material,  
26 certainly a lot of the material, is well worth  
27 reading, and of the remaining 10 percent, some of  
28 the Companies send some very valuable literature  
29  
30





1 around to the doctors. They will send around  
2 valuable literature such as dealing with emergency  
3 injuries, head injuries, injuries of the hand,  
4 injuries of the leg, put out in a very valuable  
5 manner so that it is easy to read and very inform-  
6 ative and certainly of value to the doctor. That  
7 type of literature never gets pitched out. That  
8 is taken in and kept on file.

10 The type of literature that makes  
11 up the 90 percent -- and I use these percentages  
12 very roughly -- are the ones that come in small  
13 envelopes like letters that you just would not  
14 have the time to cope with and try to go through.

15 MR. MAC LEOD: Turning to some-  
16 thing else, Doctor, in your experience has the  
17 development of new drugs within recent years made  
18 a great difference in your practice? Do you find  
19 that it is easier to cope with certain diseases  
20 now and that sort of thing?

22 DR. REARDON: I didn't catch that,  
23 sir.

24 MR. MAC LEOD: In your experience  
25 in your own practice, has the development of all  
26 the new drugs that are coming on the market  
27 materially assisted you?

28 DR. REARDON: Oh certainly.

29 MR. MAC LEOD: Perhaps you would  
30 just give us a little detail on that. Is it



1  
2 easier to cope with certain diseases now?

3 DR. REARDON: Yes, the pulmonary  
4 diseases are easier to cope with since the advent  
5 of penicillin and sulpha and so on. There is no  
6 question about that. People are getting better  
7 from certain illnesses in a matter of a few days  
8 or a few weeks that ten or fifteen years ago  
9 might have taken weeks or months. With the ad-  
10 vance of new drugs it has made a tremendous change  
11 in the outlook of people sick from many diseases,  
12 tuberculosis and pneumonia, and the advent of these  
13 new drugs has played a great part, and the reason  
14 that you have better operative results today than  
15 you did ten or fifteen years ago -- and it is not  
16 so much due to better trained operators, but you  
17 don't have to worry so much about complications  
18 that often arise with surgical operations. New  
19 drugs today look after a lot of these and it  
20 makes it safer to operate on people today than  
21 fifteen or twenty years ago.

23 MR. MAC LEOD: Is there any  
24 problem that arises because of side effects  
25 developing after a drug has been in use for  
26 some years?

27 DR. REARDON: No, people develop  
28 certain allergies to drugs. It is a well known  
29 fact. People will develop the same allergies  
30 against the use of pop and beer. It is something



1

2

that can develop allergies, but it is no different  
in drugs than foodstuffs.

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MR. MAC LEOD: I was wondering if  
sometimes these drugs are used without the knowledge  
of them being complete, that perhaps after a year  
or two some further effects come forward that put  
a different light on the use of the drug. Is that  
your experience?

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DR. REARDON: I wonder when a new  
drug comes out, if there is any way of using it,  
where do you get your research? I think that some  
idiosyncracies might crop up two or three years  
later, but I don't know how you are going to  
foresee these. Certainly the advantages over the  
years of penicillin to the public have certainly  
outweighed any disadvantages that you might get  
by the odd person who is allergic to penicillin.

MR. MAC LEOD: I take it your  
opinion would be from what you say that the ad-  
vantages in the use of a new drug even though  
everything is not known, would be beneficial?

DR. REARDON: It far outweighs  
the disadvantages.

MR. MAC LEOD: Are you able to  
keep yourself familiar with costs to the patient  
of drugs?

DR. REARDON: I do my best to keep





1 myself familiar.

2  
3 MR. MAC LEOD: Is that a difficult  
4 problem for a busy doctor?

5 DR. REARDON: It is a difficult  
6 problem for anybody. There are so many drugs  
7 the drug Companies send to doctors. He is not  
8 intimately concerned with the price of everything  
9 that may be prescribed but certainly as a general  
10 rule the doctors are interested in the welfare of  
11 their patients and try not to load them with more  
12 medicine than they can possibly handle or need.

13 MR. MAC LEOD: I take it that you do  
14 concern yourself with the question of price that  
15 your patient is going to have to pay?

16 DR. REARDON: Certainly.

17 MR. MAC LEOD: And try to keep it as  
18 reasonable as possible?

19 DR. REARDON: Yes we have no control  
20 over price.

21 MR. MAC LEOD: Do you ever prescribe  
22 drugs by their generic names?

23 DR. REARDON: No, I use the trade  
24 names.

25  
26 MR. MAC LEOD: What is your reason  
27 for doing that, Doctor?

28 DR. REARDON: You can remember the  
29 trade names far easier than you can remember the  
30 generic names and from my point of view I cannot



1  
2 see what possible difference it makes.

3 MR. MAC LEOD: I suggest to you in  
4 some cases it might make a difference in price?

5 DR. REARDON: I suggest to you in  
6 most cases it does not.

7 MR. MAC LEOD: It is your impression  
8 that brand names and generic named drugs retail for  
9 the same price or about the same price?

10 DR. REARDON: I would say in the  
11 City of Halifax that they do.

12 MR. MAC LEOD: So that --

13 DR. REARDON: For example if I was  
14 ordering chloromycetin which has a generic name of  
15 chloramphenicol, I would feel obliged to put down  
16 the name of the manufacturer whom I knew was  
17 distributing quality drugs, if that is what you are  
18 trying to get at.

19  
20 MR. MAC LEOD: I take it even if you  
21 did use a generic name you would specify the brand  
22 name by a particular manufacturer?

23 DR. REARDON: I would feel obliged  
24 to, because you are now getting to the point of  
25 the quality of drugs and why we prescribe trade  
26 names instead of generic names.

27 MR. MAC LEOD: Yes, I am getting  
28 your reaction as a doctor in general practice?

29 DR. REARDON: I would say that  
30 primarily I prescribe trade names because they



1 are easier to remember and it is the way that you  
2 are used to doing it and you get into a habit of  
3 doing it.  
4

5 MR. MAC LEOD: That is your  
6 practice?

7 DR. REARDON: If I prescribe by the  
8 generic name I would feel obliged to add to that  
9 one of the Companies who supplied that drug who I  
10 felt supplied quality drugs.

11 I don't think all the drugs coming  
12 into Canada are quality drugs and I feel that we  
13 have an obligation to our patients to see to the  
14 best of our ability that what they get is the  
15 best. The prime consideration in drugs, to my  
16 point of view, is to see that the drug will do  
17 the job that you want it to do. Price is not  
18 the prime consideration. The prime consideration  
19 is getting the patient better. After that the  
20 price must come into it, but the prime consideration  
21 is to see that the patients gets the drug that will  
22 cure that patient for that particular disease.  
23

24 THE CHAIRMAN: I just want to get  
25 quite clear what you are saying. If you use a  
26 generic name of a particular drug Company, in  
27 effect you are using the trade name of that  
28 Company?

29 DR. REARDON: Certainly. I notice  
30





1  
2 in this brief here that all the way through it is  
3 the suggestion that the small manufacturers or the  
4 small importers of drugs, who supply drugs that are  
5 cheaper in price than the well known manufacturers,  
6 do not receive the acceptance by the doctors mainly  
7 because the doctors have not been sold that these  
8 drugs are of the same quality as the other ones.  
9 I think that is an important point.

10 All the drugs are not examined by  
11 the food and drug group in Ottawa as for quality,  
12 biological and chemical quality or quantitative  
13 properties. There is no good using a drug because  
14 it is cheap if you are going to get hills and  
15 valleys in its potency in the action that it will  
16 have. If you are going to get hills and valleys,  
17 you do not know why your patient is not responding  
18 to that drug, and it is like anything else.

19 Over the years you get to recognize  
20 that a Company, whether it is A, B, or C, has put  
21 out drugs that certainly as far as you know, and  
22 you have never heard of it being otherwise, that  
23 have in their capsules or in their tablets or the  
24 kind of medicine involved, what that Company say  
25 is there.  
26

27 It is like having a Rolls-Royce.  
28 You don't worry about the quality because over  
29 the years you come to recognize that it is there  
30



1 and you come to realize that drugs supplied by  
2 certain Companies, the content in their capsules,  
3 the quality and quantity of medicine that you are  
4 prescribing are there. But you cannot be sure  
5 about a new pill by a new Company that might be  
6 set up simply for making this particular type of  
7 pill for distribution and there is no real worry  
8 about them except making money. You say perhaps  
9 there is no real worry behind the larger Companies  
10 except to make money.

12           The larger Companies spend consider-  
13 able amounts of money on research in drugs. A lot  
14 of these small outfits spend nothing on research.  
15 They may only have an office in their hat, and yet  
16 they distribute drugs they bring in from Italy or  
17 France and wonder why the general public don't  
18 accept them.

20           I think it would be very dangerous  
21 for doctors to accept some of these drugs that come  
22 in without having some standard of quality. If the  
23 Government at Ottawa through their group are  
24 responsible for quality can say to the doctors,  
25 "We are examining every batch of such and such a  
26 Company's drugs and we find that it contains the  
27 ingredients and amount it is supposed to contain,"  
28 you won't ever find lack of acceptance of the lower  
29 priced drugs that you mentioned.



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MR. MAC LEOD: When speaking of generic names and the lower cost of drugs, I take it you were speaking largely of imports?

DR. REARDON: That is right. That pretty well includes all the so-called high cost drugs, doesn't it. They are all imported.

MR. MAC LEOD: Well then, in your own practice have you had any experience at all with generic name drugs?

DR. REARDON: Certainly, whether you use them by trade or generic your experience is the same.

MR. MAC LEOD: What I was trying to get at, did you have any experience in prescribing a drug simply by the generic name without attaching any brand to it?

DR. REARDON: No, I don't do that.

MR. MAC LEOD: You don't do that. That wouldn't have arisen in your experience?

DR. REARDON: No. It hasn't arisen in my experience. I don't prescribe generics. I want to know what the patient is getting. I want to be sure what he is getting.

MR. MAC LEOD: I think, Doctor, those are all the questions I want to ask you. If there is anything in connection with the drug field that you would like to speak about that you





1 think would be of assistance to the Commission I  
2 am sure the Commission would like to hear your  
3 comments.  
4

5 DR. REARDON: I don't think there is  
6 anything very much. There is one point I would  
7 like to make -- two points.

8 First of all I would like to make  
9 the comment, I appeared here on the request of the  
10 Commission and not on my own idea. I was very glad  
11 to do it if I am of any help.

12 It would seem to me from reading the  
13 information in this book, which I find very  
14 interesting, that the cost of drugs is concerned  
15 mainly with the newer drugs, the tranquilizers and  
16 the so-called tetracyclines, and the new wonder  
17 drugs. These are all imported. I gather from the  
18 information here -- it would seem that we are trying  
19 to do something about the high cost of drugs and  
20 the drugs are all imported of which we have no  
21 control over their price, I should imagine. If  
22 anybody is concerned with anything the Government  
23 can do about the high cost of drugs, then I would  
24 think the logical place to start to reduce them  
25 would be the removal of your sales tax.  
26

27 This tax on drugs is 11 percent,  
28 which increases the cost of the drug to the patient.  
29 There is no sales tax on insulin or cortisone now  
30



1  
2 because it is felt these drugs are used on chronic,  
3 long-term cases that a patient could not pay for  
4 them. I contend a patient using the tetracyclines  
5 or the tranquilizers for an acute illness, whether  
6 it be mental or otherwise, that drug is just as  
7 important at the time they are acutely ill than if  
8 they are going to get well as is the insulin or  
9 cortisone to an arthritic. I think it is ridiculous  
10 to talk about the high cost of drugs when we pay  
11 11 percent across the board. If we are interested  
12 in the high cost of drugs then the Government  
13 should show their interest by taking off their  
14 sales tax. It would make a difference of 11 percent  
15 at least. I think it would make a difference of a  
16 little bit more because the manufacturer who has to  
17 charge sales tax to the wholesaler has also to pay  
18 the administrative sales tax.

20 You take off your tax and the admini-  
21 stration and overhead to the wholesaler goes. A  
22 hospital must have somebody looking after the  
23 rebate, keeping track of the rebate on sales tax  
24 which they have already paid to the drug manufacturer.

25 I think if the Government could get  
26 around to taking away the sales tax of 11 percent  
27 it might mean a difference of 15, perhaps 20 percent  
28 across the board to the public in the cost of drugs.

29 The only suggestion I have to make  
30



1 today is, if it is recommended drugs are basic to  
2 the well-being of the patients, certainly it should be  
3 free of sales tax which only increases the cost.

4 That is all I have to say.

5 THE CHAIRMAN: You mentioned you  
6 found no difficulty in keeping up with the new drugs  
7 coming along. We are still pretty green in this  
8 field. We only started here last week. One of the  
9 witnesses last week indicated there were, perhaps,  
10 a couple of hundred new drugs coming on the market  
11 every year. I was wondering if the work involved  
12 didn't take considerable part of your time?

13 DR. REARDON: The main point I want  
14 to make was the source of information available.

15 THE CHAIRMAN: Yes.

16 DR. REARDON: For anybody who wants  
17 to find out, it is there. No one would attempt to  
18 keep up with every single new drug on the market.  
19 If you get a group of drugs all with the same  
20 action and have the same results, then you don't  
21 have to know them all. All you have to know is the  
22 few you know are efficient and what they do.  
23 Certainly there is some time lag between the time  
24 they come out and the time you know all about them.

25 I contend the time lag doesn't make  
26 any different to the patient. A lot of the new drugs  
27 are rehashes of one you already have. They don't  
28 make a tremendous difference. You can take your



1

time and catch up with what is new.

2

3

THE CHAIRMAN: Do you mean one drug  
Company brings out a new drug that is really a new  
drug, not just a modification of something else?

4

5

6

DR. REARDON: Sure.

7

8

THE CHAIRMAN: And then other  
Companies produce drugs which are sometimes id-  
entical, sometimes slightly different but not very  
different in their operative value.

9

10

11

DR. REARDON: The effectiveness is  
pretty much the same.

12

13

14

THE CHAIRMAN: So you could pres-  
cribe a drug made by A Company or B Company or C  
Company or D Company knowing whichever Company you  
get it from, it would do practically the same thing  
for your patient, is that it?

15

16

17

18

19

DR. REARDON: Yes.

20

21

THE CHAIRMAN: Drugs that are id-  
entical will be sold under different names.

22

23

DR. REARDON: I am sure that is true.

24

THE CHAIRMAN: In some cases there  
might be a slight modification?

25

26

DR. REARDON: Yes.  
THE CHAIRMAN: You could use them  
largely interchangeably?

27

28

DR. REARDON: I don't think---it is  
difficult for a doctor to find out adequately  
about the new drugs.

29

30





1  
2 THE CHAIRMAN: The ones he needs to  
3 know about until he wants something specialized.

4 DR. REARDON: Many drugs are used by  
5 specialists that the general man will perhaps never  
6 use. Certainly you can find out and keep up without  
7 any difficulty with the new drugs you want to have.

8 THE CHAIRMAN: There are no more  
9 questions. Thank you very much, Doctor. We greatly  
10 appreciate your coming here. We are anxious to get  
11 the views of some practising physicians and surgeons,  
12 particularly physicians and to see what they feel  
13 about the whole drug situation.

14 MR. MAC LEOD: We have Dr. Reid now.

15 THE CHAIRMAN: We will hear Dr. Reid.  
16

17 JAMES WILLIAM REID, sworn  
18

19  
20 MR. MAC LEOD: What is your full  
21 name?

22 DR. REID: James William Reid.

23 MR. MAC LEOD: You are practising  
24 medicine in the City of Halifax?

25 DR. REID: Correct.

26 MR. MAC LEOD: I believe you are a  
27 specialist, are you not, in internal medicine?

28 DR. REID: Yes.

29 MR. MAC LEOD: Doctor, I am going to  
30



1 direct your attention to certain aspects of the drug  
2 field, but please do not feel bound by the question-  
3 ing. If you feel there is any comment you would like  
4 to make please feel free to do so.  
5

6 Taking the general head, first, do  
7 you in your practice find any difficulty in keeping  
8 up with the new drugs, the developments in the drug  
9 field?

10 DR. REID: Yes, it is very difficult  
11 to keep up with it, largely because it is so deeply  
12 into chemistry, new chemistry that it is not easy  
13 for the practising physician to keep abreast of it.  
14 We sometimes accept the new preparations for their  
15 clinical value, but most of us trained in our time,  
16 on the older pharmacology, we knew the drugs and  
17 could actually prepare a good many of them ourselves.  
18 This is new therapedics, and all these new chemical  
19 preparations only a chemist could be entirely  
20 familiar with the actual drug itself. We can only  
21 be familiar with its clinical behaviour in the  
22 treatment of the sick.  
23

24 MR. MAC LEOD: What sources of in-  
25 formation are available to you to find out about  
26 new drugs?

27 DR. REID: Well, the doctor goes  
28 through a number of phases in his lifetime with  
29 regard to drugs. When he is a student and has all  
30 the time in the world to study he depends entirely



1 on the original work and articles for his knowledge  
2 of drugs. Later, when he goes into practice he  
3 doesn't have time to do all that, so he gets,  
4 perhaps, information about new drugs from liter-  
5 ature which comes to him from drug manufacturing  
6 concerns. Now, he observes this literature and if  
7 he can he reads it, and as a rule does nothing about  
8 it until he has an opportunity to confirm with his  
9 own scientific, medical literature which follows  
10 quite soon, I might say.

11  
12 The better the drug, the more  
13 rapidly it is confirmed in scientific literature  
14 Not very many medical men use drugs on the say-so  
15 of the pharmaceutical manufacturer alone.

16  
17 MR. MAC LEOD: Could you give us some  
18 idea of the value to you as a practising physician  
19 of the materials sent out by the drug manufacturers?

20  
21 DR. REID: Well, there are so many  
22 different kinds of materials that come into each  
23 doctor from the drug manufacturer. The first thing  
24 he is likely to get is some rather loud bit of  
25 literature designed to draw his attention to this  
26 new preparation, whatever it may be. This type of  
27 advertising -- I am not sure that the drug trade is  
28 to blame for it, perhaps it is the advertising  
29 trade that is more to blame for it than the drug  
30 manufacturer. That is the first thing that comes  
to us, and then later come a number of reprints



1 from medical journals and research laboratories  
2 sent to us by the manufacturer. Those contain  
3 valuable information, actually, and much of their  
4 material is sometimes taken from scientific  
5 journals and research establishments. They can  
6 be of great value. That, is in the newer drugs  
7 particularly, the biological preparations and the  
8 Company sends with that material a very complete  
9 brochure covering the characteristics and its  
10 actions which is very helpful to men in active  
11 practice and is quite thorough research on that  
12 material.  
13

14 MR. MAC LEOD: Do you think that  
15 the material put out by some Companies is more  
16 reliable, in your view than that put out by others?  
17

18 DR. REID: Well, I don't know that I  
19 could answer that. Our reaction to this material  
20 is colored a little bit by the attitude towards  
21 the drug Company concerned and we are -- some of it  
22 we resent because it so blatantly advertises a  
23 combination of old drugs which doesn't have any  
24 particularly value in it, so far as I can see.

25 I would hardly be prepared at this  
26 moment to say this Company's material was useless  
27 and another Company's material was good. They all  
28 may try to put valuable literature on our desks,  
29 but much of it we don't -- we are not able to read.  
30 Too much of it has come in.





1  
2 MR. MAC LEOD: Does that mean the  
3 volume is simply too great for you to give attention  
4 to?

5 DR. REID: Yes, actually in my mail  
6 this morning the volume of literature from various  
7 drug Companies was such I wouldn't have been able to  
8 come to this Hearing if I sat down to read it. It  
9 would have taken at least half a day to read. That  
10 is not due to any one drug Company. It is due to  
11 the fact there are now so many Firms actually ad-  
12 vertising in this field, many more than we had 15  
13 or 20 years ago.

14 THE CHAIRMAN: Doctor, I wonder if  
15 we cannot get that pinned down a little bit. You  
16 said this morning there was enough advertising  
17 material on your desk to take half a day to read  
18 it. Does that happen every day, or is it an ex-  
19 ceptional occurrence to have that much literature?  
20

21 DR. REID: Actually that is almost a  
22 daily occurrence.

23 THE CHAIRMAN: Does that mean that in  
24 effect you can only read a very small part of it?

25 DR. REID: That is correct.

26 MR. MAC LEOD: And the remainder is  
27 discarded, is it?

28 DR. REID: It is discarded.

29 MR. MAC LEOD: What about the practice  
30 of the manufacturers distributing samples to doctors?



1 Do you find the provision of samples to you helpful  
2 in your work?

3  
4 DR. REID: Well, it is helpful in  
5 this way, particularly, we are actively engaged in  
6 the practice of medicine. New preparations are  
7 made with which we are not familiar. We cannot go  
8 back to our medical school's pharmacology laboratory  
9 and see these things made or learn about them  
10 directly, and we are obliged to become familiar  
11 with these drugs through the samples that the drug  
12 people send to us. It enables us to recognize the  
13 drug, whether it be a tablet or capsule and become  
14 familiar with it in that way. Otherwise we would  
15 have no idea, if we finally did decide to prescribe  
16 a new preparation for a patient, we would have no  
17 idea whether the patient was getting the exact  
18 material unless we had previously seen it and knew  
19 what it was like.

20  
21 The amount of sampling is not very  
22 great, actually. The number of tablets that come  
23 in demonstrating a new drug does not amount to very  
24 much. It is just enough to familiarize us with it  
25 and that is all.

26 MR. MAC LEOD: In your experience in  
27 the provisions of samples to you, do they serve a  
28 useful purpose?

29 DR. REID: It serves a useful  
30



1  
2 purpose, indeed it does.

3 THE CHAIRMAN: Do you actually make  
4 use of the samples in your practice?

5 DR. REID: I make some use of them,  
6 yes. In my emergency bag I carry some of these  
7 samples and try them, and those that are not used  
8 in that way are used in some other way. They are  
9 distributed to the local clinics or sent in gross  
10 into some place where they might be used.

11 THE CHAIRMAN: They are not simply  
12 thrown away?

13 DR. REID: No they are not thrown  
14 away.

15 MR. MAC LEOD: Do you keep in touch  
16 with the costs of particular drugs, what they are  
17 going to cost your patient when you prescribe a  
18 particular drug?

19 DR. REID: No, I don't dare do that  
20 because if I knew what the cost of the drug was, I  
21 might not prescribe it. So that, generally speaking  
22 I don't look very closely at the cost of drugs.

23 There are a few exceptions to that,  
24 mostly the expensive cortisones. We are very acutely  
25 aware of the cost of them but I would not dare allow  
26 the cost of drugs to interfere with my prescribing.  
27 That would be unsound.

28  
29 MR. MAC LEOD: Your principal concern,  
30



1 Doctor, is that the medicine should be the best one  
2 for the particular condition, rather than any  
3 question of what it costs?  
4

5 DR. REID: Yes. That it might be  
6 high in cost is unfortunate, and I must say that we  
7 do become familiar with the cost of a drug as time  
8 goes on, and it does cause us a little thought,  
9 perhaps, but it does not interfere with prescribing.

10 If I think the patient requires a  
11 drug, I order it, regardless of cost and mostly  
12 that does not work too much hardship, I don't think,  
13 on the patient because many of the higher cost  
14 drugs are for very brief use. Again, there are  
15 expensive drugs such as cortisone and a few other  
16 things, but most of the high-cost drugs and certain-  
17 ly the early ones, the anti-biotics as we call them,  
18 were for very short time use and the total cost on  
19 a year's budget for a family did not amount to too  
20 much, actually.

21  
22 MR. MAC LEOD: In your practice do you  
23 ever prescribe drugs under their generic names?

24 DR. REID: Well, yes I do. I do when  
25 I am prescribing. I still attempt to prescribe  
26 pharmacopaedic drugs that have been in use a long  
27 time and are standard preparations which are not  
28 expensive. Where I think they are adequate, I  
29 will use those drugs prescribing from a generic  
30





1 name. I would do that with some of the newer drugs,  
2 too, but perhaps not too frequently actually. I  
3 would mostly prescribe from the brand names, I  
4 think.  
5

6 MR. MAC LEOD: There are certain  
7 drugs which may only be sold legally under a  
8 doctor's prescription, is that correct?

9 DR. REID: That is correct.

10 MR. MAC LEOD: Does a doctor in his  
11 practice find it necessary to write prescriptions  
12 for other drugs for which no prescription is legally  
13 required?

14 DR. REID: Yes.

15 MR. MAC LEOD: Would it be in respect  
16 of those drugs that you might use generic names?  
17 We are speaking of older, more established drugs.

18 DR. REID: Yes, that is correct, but  
19 also some of the newer preparations such as  
20 meprobamate. For instance, I prescribe meprobamate  
21 rather than the brand name, not being too much aware  
22 personally of just what difference in cost there  
23 might be. Prescribing in that particular way, if  
24 I did prescribe from a generic name it would be be-  
25 cause I was making my own combination with some  
26 other drugs to be dispensed as a mixture.  
27

28 MR. MAC LEOD: Something that the  
29 druggist would have to put up in his own shop?  
30



1  
2 DR. REID: Exactly. I make a point  
3 wherever I can of prescribing in that way to make  
4 work for the druggists. I don't want them to lose  
5 all their skills.

6 MR. MAC LEOD: As a matter of  
7 interest, Doctor, can you indicate in any way the  
8 percentage of your prescriptions that would be of  
9 that type as against the percentage which the  
10 druggist would fill from already prepared material?

11 DR. REID: That would be difficult.  
12 I would imagine it would be perhaps 25 percent off-  
13 hand.

14 MR. MAC LEOD: Is there any other  
15 aspect of the drug field on which you feel you can  
16 usefully comment for the use of the Commission?

17 DR. REID: No, except that I might  
18 say I think perhaps there are certain aspects to  
19 the costs of prescriptions which are not generally  
20 recognized or spoken of.

21  
22 One is the cost of a prescription is  
23 composed of a lot of service besides the drug, and  
24 in my own practice in these days we are seeing a  
25 great many people who are living alone in rooms or  
26 in apartments. They don't have families to fetch  
27 and carry for them. Very often the cost of a  
28 prescription includes the practice of going to the  
29 house and picking it up and taking that prescription  
30



1 back to the store, dispensing it and then delivering  
2 it to the patient. That is a great deal of service  
3 to go into a prescription which sells for three or  
4 four dollars, perhaps, and that is a service to the  
5 sick which one does not hear very much spoken about  
6 and yet it happens very frequently.

7  
8 The only other thing is with regard  
9 to drug advertising. I think perhaps the medical  
10 profession itself is a little bit to blame because  
11 we have not, as far as I know, as an organization  
12 taken any definite steps to let the drug trade  
13 know that we are being pressed a little too hard  
14 with literature and that sort of thing, and I think  
15 perhaps the manufacturing chemists are using the  
16 only means they know and the only means that perhaps  
17 their professional advertising agencies know of  
18 promoting their products.

19  
20 There may be other and better ways  
21 and perhaps organized medicine might have aided  
22 the pharmaceutical houses in developing that way.  
23 I just feel that we perhaps have not complained to  
24 the drug Companies as much as we should as a  
25 profession.

26 MR. MAC LEOD: I think those are all  
27 the questions I have, sir.

28 THE CHAIRMAN: I was going to ask  
29 one further question about your comment concerning  
30



1 drugs which the law does not require to be sold on  
2 prescription only but which you find it necessary  
3 to prescribe for in order that patients will secure  
4 them. Why is it necessary to prescribe for drugs  
5 which the law does not require to be prescribed  
6 for?  
7

8 DR. REID: It is largely because I  
9 may want that patient to have a combination of  
10 drugs. For instance, I may want that patient to  
11 have simple aspirin but I may want with it some  
12 tablet or some other chemical to aid in the treat-  
13 ment of that patient, so I would have to prescribe  
14 that.

15 THE CHAIRMAN: I understand that  
16 kind of case, but I was wondering if there are  
17 cases, many or few, in which the manufacturer  
18 instructs the druggist that they should be sold  
19 only on prescription.  
20

21 DR. REID: I don't know of that.

22 THE CHAIRMAN: You don't know of  
23 any?

24 DR. REID: No.

25 THE CHAIRMAN: We heard some  
26 evidence to that effect last week and I was  
27 wondering if it was fairly common?

28 DR. REID: Actually the medical  
29 profession does not want to use in its profession-  
30 al prescriptions drugs which the patient can go





1 and buy as a chemical. For one thing, if it can  
2 be purchased over the counter, it is not likely to  
3 be a very potent thing and we would not be asked to  
4 prescribe it.

5                   There are exceptions to that,  
6  
7 aspirins and a few other preparations of that  
8 kind are available for treatment whether purchased by  
9 patients or whether prescribed by the doctor, but  
10 there are not too many. Most of the things sold  
11 over the counter are by genuine Companies, the sort of  
12 thing a patient can purchase. We prescribe largely  
13 because -- we are prescribing not single drugs in  
14 that way, but combinations.

15                   THE CHAIRMAN: Our information is  
16 in modern practice there are a great many prepared  
17 dosages and in a great many instances the doctor  
18 prescribes a drug that is already fully prepared,  
19 it is prescribed and the druggist simply marks a  
20 bottle or package.

21                   DR. REID: That is true. We have to  
22 do that with many of the new chemicals because they  
23 come just in that way and there is no other way to  
24 prescribe them. We can, of course, eventually if  
25 we find a new drug might work better with something  
26 else we can make our own dosage form and have the  
27 druggist make it up, which we do.

28                   We would generally specify that drug  
29  
30



1 by its generic name and add what we wish to it and  
2 the druggist would then make it up accordingly.  
3

4 MR. WHITELEY: Dr. Reid, in pres-  
5 cribing by generic names have you found any dif-  
6 ficulty in the quality of the product which is used  
7 to fill the prescription?

8 DR. REID: No, I haven't. To assess  
9 any difference in quality would be a rather long  
10 process, and mostly we work with the dispensing  
11 chemists as a partner, as it were, in the treatment  
12 of the sick. We expect him to use only good quality  
13 drugs in our prescriptions and, I think, by and  
14 large that is true. I think you can depend on that  
15 pretty thoroughly. I don't think any dispensing  
16 chemist would willingly, knowingly put an inferior  
17 drug in a prescription of mine, and if he did put  
18 an inferior drug into it, it would be because he  
19 did not have access or methods of confirming the  
20 quality of the drug.  
21

22 In other words that would have to go  
23 further back in its manufacture and inspection by  
24 checking, you see. Most of our druggists are  
25 completely qualified and ethical people who are  
26 using only the best quality chemical that they can.

27 MR. CARIGNAN: Dr. Reid, would you  
28 say that the detail men who come visiting have  
29 been providing you with useful information?  
30



1  
2 DR. REID: Well, yes, as a matter of  
3 fact the detail man -- here again now is an interest-  
4 ing development in this business because in the  
5 early years there weren't so very many of these  
6 fellows, and they called on us and we talked about  
7 drugs and preparations and so on and we had some  
8 time to spend with them.

9 Gradually the number of detail men  
10 increased to the point where it was becoming a  
11 problem in the doctor's office, you see, to inter-  
12 view so many and some of us have had to arrange  
13 for these interviews by appointment; that is, we  
14 have certain hours in which we interview these  
15 chaps from the drug houses.

16 I have found on occasion that these  
17 fellows have been extremely helpful, not only in  
18 providing me with information concerning drugs,  
19 but quite helpful in getting original articles and  
20 material for me that I could go back to the sources  
21 of these preparations and find how it really works.

22 I think they are a valuable  
23 contact with the doctor. So long as it doesn't be-  
24 come time-consuming I am always glad to see them.  
25 In later years the detail men have been seeing more  
26 doctors in the hospitals than they have in offices,  
27 perhaps. That is one of the changes that has come  
28 about in the method.  
29  
30



1  
2 THE CHAIRMAN: Thank you very much,  
3 Doctor. We appreciate your coming and assisting us  
4 this way.

5 DR. REID: I was very happy to come,  
6 sir.

7 MR. MAC LEOD: Mr. Kennedy of the  
8 Hospital Insurance Commission.

9  
10 CECIL HOWARD KENNEDY, sworn

11  
12 MR. MAC LEOD: What is your full  
13 name?

14 MR. KENNEDY: Cecil Howard Kennedy.

15 MR. MAC LEOD: What is your position?

16 MR. KENNEDY: I am Director of the  
17 Division of Administrative Standards of the Hospital  
18 Insurance Commission.

19 MR. MAC LEOD: That is the Hospital  
20 Insurance Commission for the Province of Nova Scotia?

21 MR. KENNEDY: That is correct.

22 MR. MAC LEOD: Is the Commission con-  
23 cerned in any way with the payment for drugs used in  
24 Nova Scotia?

25 MR. KENNEDY: We are.

26 MR. MAC LEOD: Will you just explain  
27 under what circumstances the Commission pays for  
28 drugs?  
29  
30



1  
2 MR. KENNEDY: The Commission makes no  
3 payments direct to the suppliers. The Commission as  
4 it were underwrites the cost of the hospitals'  
5 operation including the cost of drugs. The hospitals,  
6 the governing boards of hospitals are responsible  
7 for the operation of the hospital. They do their  
8 own purchasing and their costs in turn are assessed  
9 by the Hospital Insurance Commission, and if those  
10 costs are approved they are paid by the Commission  
11 in lump sums.

12 MR. MAC LEOD: Does that include  
13 drugs purchased by the hospital for out-patients as  
14 well as those receiving treatment within the  
15 hospital?

16 MR. KENNEDY: It applies only to  
17 drugs furnished to out-patients in the hospital in  
18 the course of the out-patient treatment.

19 MR. MAC LEOD: Is that the only way  
20 in which the Hospital Commission is concerned with  
21 the cost of drugs, in respect to drugs used by  
22 hospitals?

23 MR. KENNEDY: Yes, I believe that is  
24 true.

25 MR. MAC LEOD: There are no other  
26 provisions about any special classes of people in  
27 Nova Scotia getting drugs or anything like that?

28 MR. KENNEDY: No.

29 MR. MAC LEOD: Certainly not under  
30





1 the Commission.

2 MR. KENNEDY: No, that is true.

3 MR. MAC LEOD: You said a moment  
4 ago if the accounts submitted by the hospitals are  
5 approved they are paid. What sort of thing do you  
6 look for when you are checking these accounts? Do  
7 you exercise any control of the drugs used in the  
8 hospital or anything like that?

9 MR. KENNEDY: We exercise no control  
10 whatever over the specific drugs used or the  
11 suppliers that provide them. There is a measure of  
12 control used in the total over-all cost of any  
13 particular expense in the hospital. That applies  
14 not only to drugs but to all other types of  
15 supplies.

16 The Hospital Insurance Commission is  
17 dealing with public money and of course feels a  
18 certain responsibility to insure there is no waste  
19 of its value in the use of these monies.

20 MR. MAC LEOD: Apart from such a  
21 general check there are no specific restrictions on  
22 the use of particular drugs or anything like that?

23 MR. KENNEDY: None whatever.

24 MR. MAC LEOD: Can you tell the  
25 Commission -- can you tell the Restrictive Trade  
26 Practices Commission the amount the Hospital Insur-  
27 ance Commission would have paid for drugs in some  
28



1 recent years?

2  
3 MR. KENNEDY: In 1959 the total cost  
4 was \$891,181.85. In 1960 it was \$954,594.66.

5 MR. MAC LEOD: Do you have an esti-  
6 mate for the current year? A budget?

7 MR. KENNEDY: No, I haven't.

8 MR. MAC LEOD: Pardon?

9 MR. KENNEDY: I haven't.

10 MR. MAC LEOD: I notice that there  
11 was an increase of approximately ten percent in  
12 the second year over the first year you gave us. Is  
13 it your experience that the cost of drugs are  
14 decreasing?

15 MR. KENNEDY: Those are the only  
16 two years for which we have figures. Our Hospital  
17 Insurance Commission only started to operate on  
18 January 1st, 1959 so that I am giving you the  
19 total experience to date.

20  
21 MR. MAC LEOD: Is there any other  
22 information that you have that you feel might be  
23 useful to the Restrictive Trade Practices  
24 Commission?

25 MR. KENNEDY: I think there is one  
26 comment I might make in connection with the total  
27 cost. You point out the total cost apparently  
28 has risen about 10 percent. A large part of  
29 that increase over all -- it is apparently due to  
30



1  
2 an increase in volume services rendered by the  
3 hospital. The percentage total on drugs has actually  
4 dropped in 1960 from 1959.

5 MR. MAC LEOD: That is the percent-  
6 age accounting for drugs has dropped?

7 MR. KENNEDY: Yes, although the  
8 gross amount of money has been increased.

9 MR. MAC LEOD: As you have just  
10 mentioned?

11 MR. KENNEDY: Yes. I believe I  
12 have nothing more to add.

13 MR. MAC LEOD: I think that is all  
14 I have, sir.

15 MR. WHITELEY: Mr. Kennedy, do you  
16 have any hospitals in Nova Scotia grouping their  
17 purchases in any way to take advantage of large-  
18 scale buying of drugs?

19 MR. KENNEDY: I don't think I had  
20 better offer an opinion on that. We don't keep  
21 close check on the purchasing practices of  
22 hospitals. Anything I might state would be merely  
23 a general impression.

24 MR. WHITELEY: You haven't had any  
25 discussion with hospital groups as to the methods  
26 they might operate in something of that kind?

27 MR. KENNEDY: If I interpret your  
28 question correctly we have in very general terms  
29 discussed once or twice with small hospital  
30



1 groups the possibility of group purchasing, that  
2 is several hospitals in a region might co-operate  
3 in their purchasing. The suggestions have been  
4 very very general. So far as their being acted  
5 on, nothing has happened.  
6

7 THE CHAIRMAN: Thank you very  
8 much, Mr. Kennedy.

9 MR. MAC LEOD: The next name I  
10 have is Mr. Roy Grant of the Maritimes Federation  
11 of Agriculture.  
12

13 ---

14 ROY GRANT, sworn

15  
16 MR. MAC LEOD: What is your full  
17 name, Mr. Grant?

18 MR. GRANT: Roy Grant.

19 MR. MAC LEOD: What is your  
20 position?

21 MR. GRANT: I am Secretary of the  
22 Maritimes Federation of Agriculture.

23 MR. MAC LEOD: I believe you have a  
24 submission you wish to make to the Commission?

25 MR. GRANT: Mr. Chairman, I have  
26 associated with me Mrs. Nadine Archibald who was  
27 Secretary and Managing Director of the Nova Scotia  
28 Federation of Agriculture.  
29  
30



1  
2 This submission to the Restrictive Trade  
3 Practices Commission regarding the manufacture,  
4 distribution and sale of drugs is being made on  
5 behalf of the Maritime Federation of Agriculture  
6 which represents farm organizations through the  
7 provinces of Nova Scotia, Prince Edward Island and  
8 New Brunswick. It should be stated also that a  
9 resolution already submitted to your Commission by  
10 the Canadian Federation of Agriculture on the High  
11 Cost of Drugs, originated with one of our member  
12 organizations and was unanimously endorsed by other  
13 farm organizations across Canada. We are, therefore,  
14 vitally interested in the investigation which is  
15 being carried on, since this has been a matter of  
16 much concern, not only to farm people, but also our  
17 citizens generally. Realization of the need of such  
18 an investigation by our Federal authorities is indeed  
19 gratifying. We shall, however, expect that following  
20 this investigation and the recommendations by your  
21 Commission, further action will be taken to correct  
22 or direct some of the practices now being carried on,  
23 many of which have been already revealed through in-  
24 vestigation under the Director of Investigation and  
25 Research.  
26

27 We note here our complete endorsation of  
28 the submission made to your Commission by the Canadian  
29 Federation of Agriculture, of which this organization  
30





1  
2 is a member body. The submission deals with the wide  
3 problems concerning the manufacture and sale of drugs,  
4 and it would be superfluous to reiterate any of the  
5 statements. There are some points, however, that we  
6 wish to draw to your attention.

7           It should be fair to state that the record  
8 of the numerous investigations carried out during  
9 recent years by the Restrictive Trade Practices  
10 Commission bears out the fact that the many Government  
11 regulations designed in the past for the protection of  
12 consumers, have proven inadequate, and that it is  
13 imperative they should be regularly reviewed and re-  
14 vamped, with the view towards strengthening legislation  
15 to meet changing times and conditions.

16  
17           Among several senators commenting on a bill  
18 presented to the United States Congress two years ago,  
19 and the need for such legislation, Senator Philip A.  
20 Hart (Michigan) said, in part:

21           "The consumer is constantly beset on all  
22 sides by forces preventing him from making the rational  
23 choice between products which is essential to a  
24 healthy, free enterprise economy. He is bewitched  
25 by clamoring voices touting the merits of uncounted  
26 products. He is bothered by the higher and higher  
27 prices that must be paid for less and less on the  
28 kitchen shelf. He is bewildered by conflicting  
29 claims and reports. <sup>H</sup>e is dismayed by deceptive  
30



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1  
2 merchandising practices calculated to pick his pocket-  
3 book. The consumer urgently needs help."

4 That was taken from Consumer Reports dated  
5 July 1961.

6 The above statement applies in Canada as  
7 well as the United States, and we respectfully submit  
8 that your Commission in its findings in the current  
9 hearings, consider recommending the need for the es-  
10 tablishment of regular and formal avenues of contact  
11 as between the general public and the various Federal  
12 agencies having to do with consumer interest; and  
13 particularly with those responsible for the Food  
14 and Drug Act, The Department of Health and Welfare,  
15 and the Canadian Broadcasting Act.

16  
17 It is also interesting to note that just  
18 recently Senator Hart announced that he would lead  
19 an investigation by the U.S. Senate Anti-Trust and  
20 Monopoly Sub-Committee into "the shoddy, the shabby,  
21 the deceitful and misleading practices of the market-  
22 place", with hearings starting in June.

23 We suggest that the time is here when,  
24 in the interests of Canadian consumers, similar  
25 appropriate action should be undertaken by an  
26 appropriate government agency, perhaps in the nature  
27 of a Department of Consumers, as envisaged in the  
28 United States.

29 We want to say in fairness to Canadian  
30 authorities, however, that there have been occasions



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When their alertness is reported to have protected the Canadian consumer against unscrupulous drug trade practices. One such instance is reported in the December 29, 1959 issue of the Farmers' Union Herald, as below quoted:-

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"The cost of a complete set of three shots (Salk Polio Vaccine) in Canada for example, where there was rigid control on prices, was \$1.50. Prices in U.S.A. ranged all the way up to \$7.20 and \$8.10, plus doctor's fees. Later this was scaled down, but rarely as low as the Canadian prices."

14

15

The responsible Canadian authorities of that day are to be commended for their timely action.

16

Also quoting from the same publication:-

17

18

19

20

21

"In 1948, for example, the Los Angeles Better Business Bureau announced that 70% of the county's physicians were accepting financial rebates from drug stores, medical supply houses, opticians and laboratories."

22

23

24

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26

The article goes on to point out that all this is in direct violation of the ethical code of the American Medical Association, and that it would appear that this practice is considered sufficiently widespread to merit concern.

27

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Insofar as Canada is concerned, our organization has no information as to whether or not a similar situation is even mildly prevalent here.



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We would submit, however, that in fairness to the great preponderance of ethical Canadian Medical Practitioners and the consuming public, a searching investigation should be conducted to ascertain the facts.

While the preceding submissions to your Commission may have dealt largely with the cost of drugs for humans, as a farmers' organization, we are also concerned with drugs used in livestock and poultry feeds. Here again we would ask that your Commission give detailed attention to the cost of drugs used for these purposes. Animal drugs are indirectly of concern to consumers. We submit in Appendix I, a memorandum dealing with this matter, as prepared by one of our member organizations.

In concluding this brief we again wish to state that it is our hope some direct results will be obtained because of this inquiry into the manufacture, distribution and sale of drugs. It is quite possible that results are already being noted, as stated in the June 17, 1961, issue of MacLean's Magazine:

"Watch for Lower Drug Bills, as the result of new regulations by the federal food and drug directorate. Few doctors have been willing to prescribe drugs by their generic (rather than brand) names, since they aren't sure of the quality of some of the cheaper and not widely known brands. Later



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1  
2 this summer, when the new regulations come into effect,  
3 the directorate will be able to test all materials,  
4 both raw and bulk, for all foreign drugs being sold  
5 in Canada. It will also be able to insist that its  
6 inspectors investigate the factory of any company  
7 anywhere that wants to sell drugs here. This means  
8 doctors will have more confidence in all brands and  
9 patients, armed with generic prescriptions, can shop  
10 for prices."

11  
12 Such a situation as above related, together  
13 with resulting action on recommendations made by  
14 these investigations, could well help to slow down  
15 the steady erosion of the buying power of our dollar.

16 Respectfully submitted,

17 MARITIME FEDERATION OF AGRICULTURE.

18  
19 APPENDIX I

20 PRICE OF DRUGS USED IN LIVESTOCK  
21 AND POULTRY FEEDS

22 Some of the products used in the manufacture  
23 of livestock and poultry feeds other than grains,  
24 proteins, and minerals would be -

25 Vitamins - Vitamin A

26 Vitamin D

27 The B-Complex Vitamin - Riboflavin, Niacin,

28 Pantothenic Acid, Choline Chloride.

29 Vitamin E  
30





1

2

Vitamin C

3

Vitamin K

4

Vitamin B-12

5

Antibiotics - Penicillin - Streptomycin, bacitracin,

6

Aureomycin, Terramycin.

7

Coccidiostate - Zoalene, Glycamide, Nicarbazine,

8

Sulfaquinoxaline, Nidrafur, Amprol.

9

Drugs - Arsanilic Acid, 3-Nitra-4 Hydroxyphenylarsonic

10

Acid, Furazolidone (Nepzido, Enheptin -

11

Car-O-Sep) Phenothiazine, Piperazine.

12

13

Synthetic Vitamin-A in its various forms

14

with different manufacturing processes to achieve

15

stability are offered by at least four companies at

16

identical prices on the same potency basis e.g.

17

(250,000 iu/gm. material). If a price reduction or

18

increase comes in on one product the others follow

19

immediately. This also applies to Vitamin-E and

20

Vitamin-C.

21

The patent on Vitamin B-12 in Canada has

22

been held by one company and hence the price has been

23

maintained.

24

The Vitamins of the B-Complex are available

25

from a number of sources at identical prices, quantity

26

discounts, and shipping arrangements.

27

Coccidiostats - Different products originating with

28

different companies end up with the same

29

cost to medicate a ton of Chick Starter - e.g.

30



Cost to Medicate one ton of  
Feed at Recommended Level

Zoalene	\$2.20
Nidrafur	2.20
(Glycamide	2.20 (x)
Except-Nicarbazin	2.05 (x)
ion(Amprol	2.50 (x)
(Sulfaquinoxaline	1.85 (x)

(x) These four products all sold by one company.

Antibiotics - Penicillin is available from several companies in the same potencies at the same prices, the only selling point being difference in particle size, stability, etc.

Aureomycin and Terramycin although manufactured by different companies are very similar in chemical structure, reaction and effect. These two products follow identical pricing arrangements.

Conclusion - Most of the products mentioned above are available from more than one source at identical potencies and prices or similar products are available at identical pricing arrangements.

THE CHAIRMAN: Do you wish to add anything by way of comment on the brief yourself?

MR. GRANT: I don't think so at this moment, sir.

THE CHAIRMAN: Thank you. Have you some questions, Mr. MacLeod?

MR. MacLEOD: I think not sir.



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THE CHAIRMAN: I think possibly we might just mention, Mr. Grant, that our terms of reference at the present time have to do with drugs and your one suggestion of a general investigation into the whole field of industry in relation to consumers, and our terms of reference are limited to the drug field and we may not be able to go as far afield as you suggest.

MR. GRANT: I thought, sir, that the matter of advertising and radio broadcasting could properly come under review insofar as they affect drugs.

THE CHAIRMAN: As far as they impinge on the drug field, yes, but not in the general sense.

MR. GRANT: That was my intention, to restrict it to that.

THE CHAIRMAN: Thank you, Mr. Grant.

MR. GRANT: There was one observation perhaps I might make. In listening to the discussions here this morning with the doctor and the evidence that they gave, it was my feeling that the suggestion which the Canadian Federation of Agriculture had made might be very valuable, and that dealt with the recommendation that Canada should have a publication which lists, reviews and appraises new drugs for the use of medical doctors, and that such a publication should be provided at the public expense, and it is



1  
2 my recollection, too, that the suggestion included  
3 of course that the people who would prepare that  
4 would be people with medical training who would  
5 have the confidence of the medical profession,  
6 because otherwise it would not be useful.

7 THE CHAIRMAN: Yes, that submission was  
8 made to us in Ottawa last week. Thank you, Mr. Grant.

9 I think since Mr. Bell is here and we have  
10 time, we might have the brief from the Trades and  
11 Labour Council.  
12

13  
14 JAMES K. BELL, sworn

15 MR. MacLEOD: You gave the reporter your  
16 name, Mr. Bell?

17 MR. BELL: Yes.

18 MR. MacLEOD: For the record unless we have  
19 it down already, will you say who you are representing  
20 and who is with you this morning?  
21

22 MR. BELL: The Halifax-Dartmouth and  
23 District Labour Council, C.L.C. and I am accompanied  
24 by Mr. Gordon A. Smith of that same body and also Mr.  
25 George A. Smith, local representative of the Canadian  
26 Labour Congress.

27 THE CHAIRMAN: And your own position with  
28 the District?

29 MR. BELL: I am treasurer of the Halifax-  
30 Dartmouth and District Labour Council. This is a



1  
2 brief of the Halifax-Dartmouth and District Labour  
3 Council (C.L.C.) to public hearing held by the  
4 Restrictive Trade Practices Commission in Halifax,  
5 Nova Scotia, July 10, 1961.

6  
7 Mr. C. Rhodes Smith, Chairman,

8 Mr. A. S. Whiteley, Member,

9 Mr. Pierre Carignan, Member.

10 Gentlemen:-

11           The Halifax-Dartmouth and District Labour  
12 Council (C.L.C.), like many other public organizations  
13 interested in the health and welfare of Canadian  
14 citizens, appreciates this opportunity of appearing  
15 before your Commission and making known its views  
16 with regard to what we consider the exorbitant prices  
17 being charged the people of Canada who find themselves  
18 obliged to take medication.

19  
20           We are aware that other sections of the  
21 trade union movement in Canada, along with our parent  
22 body, the Canadian Labour Congress, are presenting  
23 more comprehensive briefs showing detailed facts and  
24 figures of the excesses found in the drug dispensing  
25 industry. We do, however, wish to make general  
26 comment on what we consider are the main factors re-  
27 sulting in high drug costs and what can be done to  
28 alleviate them; and also to bring before the attention  
29 of your Commission certain local experiences as re-  
30 ported by members of our affiliated unions.





1  
2 Our Council is aware of the report sub-  
3 mitted to your Commission by the Combines Branch of  
4 the Federal Department of Justice which represents  
5 a three year study of drug prices in Canada. We  
6 concur with the general findings of that report, in  
7 which it states that the four factors responsible for  
8 high drug costs in Canada are as follows:-

9 (1) Monopoly control by manufacturers over  
10 many valuable drugs through exclusive patent rights.  
11 Drug manufacturers recorded a 10.5 percent profit --  
12 one of the highest in Canada -- in 1958, the report  
13 states.  
14

15 (2) Costly and largely unnecessary advertis-  
16 ing, promotional and research activities. Advertising  
17 costs were 25 percent of the sales incomes, according  
18 to a survey of drug firms.

19 (3) No price competition among retail drug  
20 stores. Usual agreed mark-up is close to 40 percent.

21 THE CHAIRMAN: That is no price compe-  
22 tition, is that what is really meant there?

23 MR. BELL: Yes, that is right, no price  
24 competition.  
25  
26  
27  
28  
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"(4) A federal sales tax of  
11 percent.

Many drug products sold in  
Canada originate in the United States.  
Drugs, manufactured and patented in the U.S.  
under laws which give the manufacturer a  
virtual monopoly over his product, are  
supplied to the Canadian market either directly  
or through a Canadian subsidiary. Many of  
these drugs are priced as high as the same  
drug sold in the U.S., and without federal  
sales tax or 11% added, this has the  
effect of making Canadian prices higher than  
U.S. prices, and gives Canada the distinct-  
ion of having the highest drug prices in  
the world.

In accepting the claim that  
most drug products sold in Canada originate  
in the United States, it would therefore  
follow that the disclosures being made by  
Senator Estes Kefauver's inquiry into the  
ethical drug industry are reflecting them-  
selves in a similar light insofar as  
Canadian experience is concerned. For ex-  
ample, it was brought out that tablets  
(Prednisone) could be made for 1.6¢ each.  
These were sold to retail outlets for \$17.90  
a hundred, while the customer was charged



1 30¢ each. Even locally they are sold for  
2 32¢. Another drug which sells regularly  
3 at \$39.50 a thousand had been offered to  
4 the USA government for 60¢ a thousand.  
5

6 It is also interesting to note  
7 that one of the factors in drug costs is  
8 the excessive and unnecessary advertising  
9 carried on by the drug firms who send out what  
10 amounts to practically a deluge of circulars  
11 and samples to local physicians who do not  
12 have the time or interest to read or test  
13 the samples supplied. For example, Dr.  
14 James E. Bowes, of Salt Lake City, Utah,  
15 when appearing before the Kefauver Sub-  
16 committee, pointed out that he had kept a  
17 careful record for months of the circulars  
18 and samples that he had received from drug  
19 companies and that "if all other practicing  
20 physicians received the same material, it would  
21 require two railway mail cars, 110 large mail  
22 trucks and 800 postmen to deliver a single  
23 day's mailing to the doctors." "Then" he  
24 declared, "it would take over 25 trash  
25 trucks to haul it away to be burned on a  
26 dump pile whose blaze would be seen for 50  
27 miles."  
28

29 Dr. Bowes estimated that the weight  
30



1 of drug circulars mailed in one year at  
2 24,247 tons. He said the wholesale cost  
3 of "free" samples received in the mail comes  
4 to \$86.2 million a year, to which could be  
5 added another \$86.5 million worth of samples  
6 left with doctors by detail men. The \$12  
7 million paid by the drug companies merely  
8 for bulk rate postage on circulars and samples  
9 would build three large hospitals a year.  
10 Probably, he added, "50 hospitals could be  
11 added to this figure if we had the amount of  
12 money that the pharmaceutical houses annually  
13 throw into the doctor's wastebaskets."

14  
15 It is interesting to note that the  
16 report of the Combines Branch of the Federal  
17 Department of Justice, in reviewing the  
18 Canadian experience in the cost of advertis-  
19 ing and promotion of the drug industry,  
20 makes the claim that the cost of advertising  
21 and promotion is one of the major expenses of  
22 doing business and is, of course, reflected in  
23 the prices charged for the product.  
24

25 It is also significant to learn  
26 that the Combines Branch report shows that  
27 mark-ups by manufacturers often far exceed  
28 production and research costs. We agree with  
29 the findings that the high-pressure  
30 promotion leads to multiplicity of



1 substantially similar products which have  
2 "no medical justification to be marketed and  
3 sold, and the wide-spread use of complicated  
4 and potentially danger-drugs for trivial ill-  
5 nesses is being encouraged."

6 We would welcome a government agency  
7 investigating many of these widely ad-  
8 vertised and highly promoted cure-all  
9 drugs (cortisone, prednisone, prednisolone,  
10 dexamethasone, promazine, perchlorperazine,  
11 etc.)

12 We believe that genuine research is  
13 of great benefit to the people and the  
14 public is prepared to absorb the cost of  
15 research in the purchase of drugs. There is,  
16 however, a practice of producing combinations  
17 which are slightly different from the basic  
18 drug or from other combinations already on  
19 the market and promoting these new combin-  
20 ations almost invariably under trade names  
21 as new and important discoveries.

22 We join with other consumer  
23 groups in requesting that legislation or  
24 regulations be enacted whereby a standard  
25 description of drugs be mandatory and that  
26 this standard description be prominently  
27 printed on the drug container or package.





1 In other words, we feel that all prepared drugs  
2 should be described by their generic name  
3 as well as the brand name. There appears to be a  
4 widespread use by physicians of prescribing  
5 drugs by brand names rather than by the  
6 generic names of the drugs to the dis-  
7 advantage of the patient, who is obliged  
8 to pay a higher price for his drug under  
9 a brand name purchase. The cost is further  
10 increased by the addition of a minimum  
11 prescription fee charge.  
12

13 We are disturbed by the  
14 recent disclosures that a leading drug  
15 firm (Parke Davis & Co.), which maintains a  
16 Canadian subsidiary, has been singled out  
17 by the United States Supreme Court as  
18 having violated the Sherman Anti-Trust Act  
19 through its action in threatening to shut  
20 off supplies to retailers who sold at cut-  
21 rate prices. In view of the fact that many  
22 American firms having subsidiaries in  
23 Canada carry on the same business policy in  
24 both countries, we feel that this revelation  
25 should be of sufficient concern and interest  
26 to your Commission to investigate whether a  
27 similar policy is being practised by this  
28 Company and other Companies in Canada.  
29  
30



1  
2 Members of our affiliated  
3 unions have reported that there appears to  
4 have been an increase in the prescription  
5 fee charged by local drug retailers. With-  
6 in the last year our members have complained  
7 that a 75¢ prescription fee for each prescription  
8 filled is being charged. This appears to be  
9 a general practice and suggests that it was  
10 arrived at during a conference or meeting  
11 of retailers. We question whether this is  
12 permissible under existing legislation and  
13 regulations.

14 One of the complaints which many  
15 of our members make is that quite frequently  
16 prescriptions are merely patent drugs sold in  
17 smaller quantities at higher prices and with  
18 the prescription fee added. We feel that  
19 both the physicians and the retailers are  
20 jointly responsible for these unnecessary  
21 high drug costs, and we would therefore urge  
22 that regulations be enacted whereby whenever  
23 prescriptions are filled from patent medicines  
24 that this be indicated on the container or  
25 package."  
26

27 THE CHAIRMAN: I was going to  
28 remark, on this patent medicine that patent  
29 medicine normally does not mean medicine for which  
30



1 a manufacturer has the patent right.

2 MR. BELL: No, no, the more  
3 commonly prepared medicines that are packaged.

4 THE CHAIRMAN: That is what you  
5 are referring to?

6 MR. BELL: Not necessarily patent-  
7 ed by law.

8 "It has also come to our  
9 attention that in other parts of the  
10 country, a practice has been initiated  
11 whereby physicians, in collusion with re-  
12 tailers, are marking prescriptions which  
13 indicate to the retailer the price which  
14 should be charged for the drug, so that no  
15 discrepancies take place whenever prescriptions  
16 are filled at different retail outlets.  
17 While this practice has not come to light  
18 locally, we would nevertheless join in  
19 asking that legislation be enacted which  
20 would make it illegal for any code to be  
21 included on a prescription which in any way  
22 relates to the price to be charged."

23 Since preparing that, Mr. Chairman,  
24 we have learned there appears to be a practice  
25 when it comes to repeating the prescription when  
26 the customer asks for a copy of the prescription  
27 and where it is permissive the retailer supplies  
28  
29  
30



1 him with a copy of the original prescription and  
2 there appears to be a code because the price  
3 charged by the other retailer works out to the  
4 same price too frequently to be a coincidence.

5 THE CHAIRMAN: I am just wonder-  
6 ing, at the top of the paragraph, "a practice  
7 has been initiated whereby physicians in collusion  
8 with retailers" -- what part would the physician  
9 have to play?

10 MR. BELL: We feel -- this is not  
11 a local situation, but we have heard this that it  
12 has been brought out that they physicians have  
13 had an interest or kick-back, rebate from the  
14 druggist and they have been apparently supplied  
15 with a suggested price list. We have also, for  
16 example heard here locally there is a suggested  
17 price list that has been available to the retailer  
18 and on which the unit cost has been set out, and  
19 that apparently is part of the process of the  
20 retail druggist.

21 In this case, apparently, on other  
22 parts of the country and particularly in Western  
23 Canada we have heard through the Labour movement  
24 that some of the doctors have been quoting the  
25 price when writing out prescriptions.

26 THE CHAIRMAN: You mean the  
27 physician in writing the prescription will actually  
28  
29  
30



1 put a price on it?

2  
3 MR. BELL: Code a price. To be fair  
4 we don't know this is practised locally, but we have  
5 heard of it elsewhere and we are bringing it before  
6 this Commission so steps can be taken to prevent  
7 the further spreading of this unethical practice.

8 THE CHAIRMAN: The reason I was  
9 questioning you we have not heard that particular  
10 complaint up to the present time. I want to be  
11 sure we know exactly what it means. We have had  
12 some intimation that sometimes the druggists who  
13 have had a prescription and are asked for a copy  
14 so it might be taken to another druggist, they may  
15 have a code mark put on that indicates the price.

16 We have heard something of that,  
17 but we have not heard anything of the physician  
18 fixing the prices.

19 MR. BELL: The complaints of  
20 copying prescriptions have been brought to our  
21 attention by members here and it appears to be  
22 practised locally, but we haven't run into the  
23 other situation yet. We have heard it has taken  
24 place elsewhere. There are certain arrangements  
25 made between the physician and the retail drug  
26 house which we feel certainly could be corrected  
27 by having legislation passed that would make it  
28 illegal for any code to be included on a pres-  
29 cription.  
30





1  
2 THE CHAIRMAN: Up to the present time  
3 we have no evidence of physicians getting kick-backs  
4 from druggists.

5 MR. BELL: "You can appreciate that our  
6 organization represents a large section of the  
7 community who are in the lower wage brackets and  
8 who, therefore, find it more difficult to  
9 meet the high, unfair and unnecessary drug  
10 charges.

11 We are located in a region where  
12 rates and income according to the Gordon  
13 Commission, are approximately 30% lower than the  
14 national average, and it would therefore  
15 follow that the working people of this area  
16 find it more difficult to meet their oblig-  
17 ations and responsibilities, including drug  
18 costs."

19  
20 On that point, Mr. Chairman, I  
21 would like to point out if it is found that the  
22 practice of setting prices through a suggested list  
23 price operates on a national pattern prepared out-  
24 side of this region it makes it a double burden on  
25 the people of this particular area to pay the  
26 suggested list price while living at the standards  
27 here. Our income is much lower than in other parts  
28 of the Country. We trust that your Commission will  
29 help to rectify this situation. Respectfully  
30 submitted.



1 THE CHAIRMAN: Mr. Bell, would you  
2 like to make any comments in addition to what you  
3 have already stated as you went along?  
4

5 MR. BELL: No, not at all. I think  
6 we have pretty well generalized the situation. We  
7 haven't heard of too many complaints which single  
8 out the local drug retailers as carrying on any  
9 type of practice, but what appears to be the  
10 pattern across the whole Country -- it appears this  
11 situation has become practically national and there-  
12 fore certain of these practices are being carried  
13 on here, being part of the accepted pattern that is  
14 taking place over the whole of the Country, and  
15 therefore we feel some Federal measure should be  
16 taken in order to try and check these excessives.  
17

18 We know when the trade union tries  
19 to get down the cost of living and negotiate with  
20 the employers for a few cents for the workmen we  
21 get all kinds of publicity and criticism while, at  
22 the same time, there are other sections of the  
23 community who make a much better living than we do  
24 and are carrying on practices that are far more  
25 unethical than the trade unions who are representing  
26 the working people in order to obtain a decent,  
27 fair standard of living.

28 THE CHAIRMAN: I would like to make  
29 one point clear. In your brief you refer to the  
30 document which the Combines Branch submitted to the



Commission as a report. So the record will be clear and you will understand the position it expressly states it is not a report under the Combines Investigation Act. It is a selection of material which the Director has got together and which he has submitted to this Commission to form the basis on which we will proceed with further inquiry.

It is factual information obtained from various sources including drug Companies, Associations, and so on. It does not purport to be a report under the Combines Investigation Act. The report when made will come from this Commission. This is material to help us get on.

MR. BELL: Knowing the slowness and the reluctance with which the Government take up matters of this kind we can only conclude there was enough smoke in the situation for the Government to get in and initiate that first stage of the inquiry and prepare the information.

THE CHAIRMAN: There has been a lot of work done in preparing this material, a great deal of work. I wanted you to know it isn't a report on which any action will be taken. The report will come after we have completed the inquiry.

Mr. MacLeod, have you some questions you would like to ask Mr. Bell?



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MR. MAC LEOD: No, sir.

THE CHAIRMAN: Thank you very much,  
Mr. Bell. We appreciate your preparation and sub-  
mission to this Commission.

MR. MAC LEOD: I think you said Mr.  
Marshall should appear at 2:15 this afternoon, and  
he will be next.

THE CHAIRMAN: In that case we will  
adjourn the Hearing until 2:15 this afternoon.

---WHEREUPON THE HEARING ADJOURNED TO 2:15 P.M.



1  
2 ---ON RESUMING AT 2:15 P.M.

3 DR. C.S. MARSHALL, sworn

4  
5 MR. MAC LEOD: What is your full  
6 name, Dr. Marshall?

7 DR. MARSHALL: Clyde Slocum Marshall.

8 MR. MAC LEOD: And you are with the  
9 Department of Public Health of the Province of  
10 Nova Scotia?

11 DR. MARSHALL: That is right.

12 MR. MAC LEOD: What position do  
13 you hold in the Department?

14 DR. MARSHALL: Administrator for  
15 National Health Services.

16 MR. MAC LEOD: Are you largely  
17 concerned with the treatment of the mentally ill  
18 in Nova Scotia?

19 DR. MARSHALL: Yes, the Government  
20 programme for the treatment of the mentally ill.

21 MR. MAC LEOD: What responsibility  
22 does the Government of Nova Scotia assume in the  
23 treatment of the mentally ill in this Province?

24 DR. MARSHALL: Well it has changed  
25 its role in recent years. Originally the interest  
26 of the Province was largely a hospitalization one.  
27 of taking care of people who needed to be taken  
28 away from the community. The original Government  
29  
30





1  
2 role in mental health was largely a protective one  
3 from people who were considered to be dangerous  
4 and difficult, and in recent years it is becoming  
5 changed over into a curative one and we are ex-  
6 tending our services not only to the treatment of  
7 patients in mental hospitals but to the treatment  
8 of patients in the community, and we are finding  
9 we can cut down in the amount of hospitalization.

10 We can do a great deal more if we  
11 get the patient earlier, so we are extending our  
12 service as rapidly as finances permit and if we  
13 can get staff to undertake a programme in the  
14 community that is an advanced programme to prevent  
15 illness before it reaches the stage of hospitalization,  
16 that is what we are trying to do.

17 MR. MAC LEOD: Does the Nova Scotia  
18 Government operate the Nova Scotia Hospital?

19 DR. MARSHALL: Yes.

20 MR. MAC LEOD: At or near Dartmouth?

21 DR. MARSHALL: Yes.

22 MR. MAC LEOD: Does it operate any  
23 other mental institutions in the Province?

24 DR. MARSHALL: It operates through  
25 the Department of Public Welfare the training school  
26 for retarded children, that is the Provincial  
27 institution, and then it has a psychiatric section  
28 or service in the Victoria General Hospital as part  
29  
30



1 of the Victoria General Hospital. It provides  
2 financial assistance to certain municipal hospitals.

3  
4 Mr. Commissioner, in Nova Scotia  
5 we are taking care of the mental health problem  
6 somewhat differently from elsewhere. The Provincial  
7 responsibility is for the acute treatment hospital  
8 which is at Dartmouth, and it also keeps there some  
9 patients who are too disturbed to be dealt with  
10 elsewhere, but the remainder, that is the large  
11 group of chronic patients, are in eight chronic  
12 mental hospitals which are operated by the  
13 municipality. Part of the cost, half, is paid by  
14 the Province provided certain standards are met.  
15 This is different from most other places you will  
16 come across. It is a somewhat different plan.

17 MR. MAC LEOD: Could you say some-  
18 thing about the impact of the tranquilizers in  
19 the treatment of mental health, speaking against  
20 the background of your own experience in this  
21 Province?

22 DR. MARSHALL: The impact of  
23 tranquilizers has simply been enormous and ter-  
24 rific and there is no other way of speaking of  
25 it. When you are trying to find out exactly  
26 what it amounts to, to put it on a scientific  
27 basis and say this improvement is due to  
28 tranquilizers and this is due to something else,  
29  
30



1  
2 you are hard put to produce accurate figures be-  
3 cause within the last fifteen years we have done a  
4 great many other things. We have produced more  
5 doctors. We have got better hospitals. We have  
6 made administrative changes in our hospitals, so  
7 that if you ask me to scientifically validate the  
8 fact that this particular change is due to drugs  
9 alone, it is not true, but the drugs themselves,  
10 the tranquillizing drugs as a group, have produced,  
11 without being able to prove it scientifically, a  
12 tremendous impact on our hospital care and  
13 specifically one could point out, for instance,  
14 in our chronic hospitals we are able to show you  
15 an example where you have the whole hospital ward  
16 of chronic patients. If you go into the hospital  
17 you can find a whole ward of patients who are not  
18 confined to their rooms.

19  
20 Take, for instance, the Cape Breton  
21 Hospital, a 25-ward hospital where years ago every  
22 day the patients were locked in their rooms or  
23 confined to their rooms. Now you will find whole  
24 wards of patients who are never locked in their  
25 rooms. The same is true everywhere. Mental  
26 hospitals are getting to be more pleasant places  
27 to work in.

28 We sometimes have people who go  
29 through our hospitals, who after they have gone  
30



1 through the hospital want to know where the real  
2 crazy people are, people that they expected to see  
3 in a mental hospital are not there any more. That  
4 is what they believe, or they feel that we have  
5 sort of played a trick on them by only showing  
6 them through the better sections of the hospital.

7  
8 A great deal of that is due to the  
9 tranquilizing drugs. Tranquilizing drugs have in  
10 some instances replaced certain forms of shock  
11 therapy. In trying to review for the Commissioner  
12 just what has happened, if one looks at what has  
13 happened to mental hospital care of mental health  
14 in the last 25 or 30 years, -- before that it was  
15 a pretty hopeless proposition. You just expected  
16 people to stay in mental hospitals, you did not  
17 anticipate people would get better. But now you  
18 do, and this is brought about by three lines of  
19 thought.

20  
21 The first is that we have become  
22 aware of psychological mechanisms for the indivi-  
23 dual, and secondly we have begun to get into  
24 physical therapy, such as shock treatments and  
25 insulin and what-not.

26 The third thing which is taking  
27 place is changing over to drugs and tranquilizers,  
28 and in some of our clinics there are still a  
29 large percentage of people who are getting these  
30



1 physical forms of therapy. In Wolfville, for in-  
2 stance, where they used to admit even general  
3 hospital patients for shock treatment, they  
4 practically have abandoned that, and have gone  
5 over to drugs.  
6

7 In other clinics they are not so  
8 certain about physical forms of therapy such as  
9 shock therapies and they still continue to play  
10 a considerable role.

11 What the future will be, I do not  
12 know, because when you say "tranquilizers", I  
13 take it you are meaning all of the drugs, the  
14 anti-depressants which are not exactly tranqui-  
15 lizers but which have the same effect of curing  
16 mental patients, the derivatives of tranquilizing  
17 drugs which operate somewhat differently, and  
18 these, I think, will be playing an increasingly  
19 important and significant role.  
20

21 Also we will go further than this  
22 and feel that a well organized drug treatment  
23 programme could keep a lot of patients out of the  
24 mental hospital who would never need to get there  
25 in the first place. Following that up, patients  
26 who are discharged from a mental hospital and  
27 return to the community, who are able to stay in  
28 the community, quite frequently are able to do  
29 that only with the help of tranquilizing drugs.  
30 They are sometimes apt to go back to the mental





1 hospital if the drugs run out or they cannot get  
2 them or they cannot afford them.

3 So that somewhat differently from  
4 one of the people who spoke to this Commission  
5 this morning, these drugs are not for the short-  
6 term cases, as in the case of anti-biotics. These  
7 are for the long-term patient, and in many in-  
8 stances patients will have to take them for the  
9 rest of their lives.  
10

2 11 So for a group of patients the  
12 problems of the cost of tranquilizing drugs is  
13 a very serious matter indeed.

14 MR. MAC LEOD: What can you tell  
15 the Commission, Doctor, about patients being dis-  
16 charged from hospitals earlier as a result of  
17 tranquilizers? You touched on that, I know.

18 DR. MARSHALL: Yes, the new forms  
19 of treatment of which tranquilizers is one of the  
20 greatest, have reduced the length of stay in mental  
21 hospitals enormously. It is very difficult to  
22 really put your finger on this and give you what  
23 I consider a scientifically validated number for  
24 this, but I would say due to tranquilizing drugs  
25 this has been the result, but so much else has  
26 gone on in the treatment of mental illness besides  
27 the drugs, that I cannot say for sure.  
28

29 Nevertheless if you look at the  
30 Dominion Bureau of Statistics figures you will



1 find as I have that drugs have played a great role.

2 In that connection I would say  
3 that about three years ago it was the first time  
4 that beds in mental hospitals in Canada ceased to  
5 increase in number. I mean they reached their  
6 maximum and are beginning to fall off. I am quite  
7 convinced that part of this, and probably the most  
8 significant part of this is due to tranquilizing  
9 drugs. This reduction is not due to the fact that  
10 there are fewer mental patients, because the ad-  
11 mission rate continues to rise and rise at a  
12 terrific rate. This increase in admission rate is,  
13 I think not due to the fact that there are more  
14 mentally ill but that people realize they can get  
15 treated and they go to hospitals, and so on and  
16 the sharply rising rate, if you look at the figures  
17 show an enormous rise in our hospital population  
18 and the fact that the number of patients who are  
19 in hospital, this is a terrific change over the  
20 last several years, and I myself would put  
21 tranquilizing drugs as one of the major factors  
22 for this change.

23 MR. MAC LEOD: Do you mean,  
24 Doctor, that now you don't have long waiting lists  
25 of people who are seeking to get in?

26 DR. MARSHALL: No, we don't here  
27 but we have an increasing number. For instance  
28  
29  
30



1 at the turn of the century we admitted 100 patients  
2 a year and around 1925 it began to rise, and last  
3 year we admitted 1300.

4  
5 THE CHAIRMAN: 1300 as against 100?

6 DR. MARSHALL: 1300 as against 100.

7 THE CHAIRMAN: And how many more beds  
8 would you have now as compared with then?

9 DR. MARSHALL: Very few more. These  
10 chronic hospitals show a terrific increase. One  
11 looking at it would wonder whether you were just  
12 getting more and more mentally ill patients.  
13 Research has been done on this which would indicate  
14 this is not the case.

15 What we are doing is creating an  
16 atmosphere where it is worthwhile to send a  
17 patient to a mental hospital to get well.

18 I started practising in 1924 and at  
19 that time you would not send your tuberculosis or  
20 mental patients to hospital because, what was the  
21 use? Why bother?

22 THE CHAIRMAN: But what percentage  
23 would you say are incurable, that is permanently  
24 in hospital?

25 DR. MARSHALL: It is hard to answer  
26 that because patients come in and go out and may  
27 come back again and you cannot use discharge  
28 figures from a mental hospital as evidence of cure.



1  
2 Suppose you say we discharged 90  
3 percent. I can tell you last year at the Nova  
4 Scotia Hospital we admitted around 1300 and we  
5 sent to chronic hospitals about 120. There were  
6 about 30 or so died and the remainder went to  
7 their homes.

8 So that is an enormous return to  
9 the community. Out of say 1300 admission, 120  
10 were considered to be -- less than 10 percent --  
11 were considered to be chronic enough to send to  
12 a mental hospital. Then when you get this group  
13 who are then in the chronic population, the  
14 discharge rate from that is low.

15 Therefore I think mental illness  
16 at this point is like a severe chronic disease,  
17 like arthritis or like one of the cancers.  
18 These are malignant forms -- schizophrenia be-  
19 longs to that group. Once they get a person to  
20 a chronic mental hospital the chances of being  
21 discharged from there to home is very much  
22 smaller, although even there with the newer  
23 tranquilizing drugs the increase is becoming  
24 larger, more noticeable and greater. Therefore  
25 the longer the illness has been in existence  
26 the less likelihood there is of discharging  
27 the patient with, what you might call, reasonable  
28 adjustment in society.  
29  
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1 That is the reason why it is im-  
2 portant for us to go even further than this, pick  
3 the patient up, not waiting until he gets to the  
4 hospital so to establish community mental health  
5 centres where they will come before they would be  
6 willing to go to hospital. Even if we could ex-  
7 pand it and furthermore I think we could cut very  
8 seriously that 120 per year we sent to the chronic  
9 population if we got them in that stage.

11 MR. MAC LEOD: Is there a balancing  
12 of costs here in the sense you have to spend money  
13 for tranquilizers on the one hand and on the other  
14 hand you would discharge your patients sooner?

15 DR. MARSHALL: Yes, we spend  
16 quite a bit of money in tranquilizers. We don't  
17 have too much money. Our costs of our mental  
18 hospitals are rising like all mental health. I  
19 have evidence, when I started as Administrator of  
20 the Mental Health Centre in 1947 -- that is 14  
21 years ago -- at that time they were spending on  
22 mental health in the Province of Nova Scotia,  
23 from the Provincial Government point of view that  
24 is, the Government programme was \$400,000.00 then.

25 This year it would be around  
26 \$3,500,000.00. That is 14 years.

27 It is not all drug cost. It is part  
28 of it. I was checking before I came here. I  
29  
30





1 don't have -- our accounting does not break down  
2 our purchases -- we don't have too good a cost  
3 accounting system to break it down into detail.  
4 But again I can mention roughly some general  
5 figures. When I took over in 1947 our total cost  
6 of medical and drug expense was \$9,194.40. The  
7 year just completed, March 31st 1961 we spent at  
8 the Nova Scotia Hospital, which was a comparable  
9 figure there, \$75,869.83 on medical and drug  
10 expenses. That is not all tranquilizers. Of  
11 that \$75,000.00 we spent roughly \$20,000.00 on  
12 laboratory and X-ray supplies. We spent \$31,000.00  
13 on tranquilizers and we spent \$24,000.00 on  
14 other drugs. That is for the Nova Scotia Hospital  
15 alone, so that on the tranquilizers for the  
16 Nova Scotia Hospital it was \$31,000.00. We paid  
17 \$34,000.00 to be distributed to such of the  
18 municipal mental hospitals of which I mentioned  
19 earlier.  
20

21  
22 MR. MAC LEOD: These are  
23 tranquilizers?

24 DR. MARSHALL: They were. We  
25 provide these tranquilizers for such of these  
26 municipal hospitals as we reach certain standards.  
27 So we spent altogether for tranquilizing drugs  
28 last year about \$65,000.00. That is quite a  
29 large budget to be spending on that. This  
30



1 doesn't include all the cases in clinics we have in  
2 the Province. I told you part of our programme to  
3 move into clinics. We have seven mental health  
4 centres and they -- we don't provide drugs for them.  
5 I would like to. We can't. Some of these get a-  
6 round this by doing some research for the drug  
7 Companies. One of our better clinics tested out  
8 one of the proprieties for research. This was one  
9 who liked this particular preparation and since  
10 taking it they practically dropped shock therapy.

12 They get from the drug Companies  
13 quite a bit of their distribution. They are able  
14 to provide for the patients that need it. In  
15 many places they are not so convenient and problems  
16 arise.

17 MR. MAC LEOD: I think you said,  
18 Doctor, when a patient returns to the community,  
19 to his own home, wherever he is going, if he re-  
20 quires drugs he has to supply them himself.

22 DR. MARSHALL: He has to carry it  
23 on his own. Some are very expensive, very big  
24 amounts. Unless he happens to be in an area  
25 where he can get quite a few free samples and  
26 he will get along -- otherwise we haven't -- I  
27 would like to document this. I can't really  
28 prove it. We then may find it necessary to  
29 return him to the Nova Scotia Hospital at very  
30



1  
2 considerable expense because he just doesn't get  
3 the drug. This seems to me is one of the very,  
4 very serious public health problems because I am  
5 quite sure we could keep in the community quite a  
6 large number of people, prevent them from going to  
7 the hospital without having to have the stigma of  
8 being in a mental hospital if we could provide  
9 them with drugs.

10 I think we could cut the number of  
11 eventual returns that go out again, Someway if  
12 the public is to be concerned with this, which I  
13 think is a very serious public health problem, of  
14 coping with this very, very difficult problem.

15 MR. MAC LEOD: In the material  
16 which the Director collected and presented to the  
17 Commission he has noted an extract from the Halifax  
18 Chronicle Herald of February 26, 1960 which is  
19 provided by Mr. Crook, Executive Director of the  
20 Nova Scotia Division of the Canadian Mental Health  
21 Association. Would you look at that and tell me  
22 if Mr. Crook's statements agree with your experi-  
23 ence?  
24

25 THE CHAIRMAN: What page is that?

26 MR. MAC LEOD: Page 93, sir.

27 DR. MARSHALL: Well, there was a  
28 follow-up on this. I am not sure whether this is  
29 so. Mr. Crook says here they frequently have to  
30



1 be recommitted for care. I will read a paragraph:

2 "Patients who have been dis-  
3 charged from mental hospitals frequently  
4 have to be recommitted for care because they  
5 are unable to afford the high cost of drugs."

6 That is true, but how frequently  
7 that is I don't know.

8 "Frequently it was solely the use  
9 of tranquilizing drugs which maintained the  
10 stable mental balance of a person seeking to  
11 re-establish himself in society."

12 That is true.

13 "Bills of \$50.00 a month were  
14 common. There are few people who can con-  
15 stantly find this amount, or often a larger  
16 sum, month after month. But it cost \$210.  
17 00 a month to keep a patient in hospital."

18 It costs more than that. I don't  
19 really know what the cost to patients is. I  
20 don't myself know.

21 I know it is a serious problem  
22 and we do see these patients back. We are at  
23 our wit's end to find a means for coping with  
24 it.

25 I myself have asked the Govern-  
26 ment if they would consider providing free drugs  
27 for people who cannot afford them. The  
28  
29  
30



1 Government has not accepted at the moment. It is  
2 a matter that concerns me greatly.

3 THE CHAIRMAN: Have you made any  
4 estimates as to what it might cost the Government  
5 if they did that in the Province of Nova Scotia?  
6

7 DR. MARSHALL: We made various  
8 estimates which weren't reliable. I could hardly  
9 say what they would cost. I will put it this  
10 way. We decided that in all fairness we would  
11 have to put it on a very restrictive programme  
12 at the beginning. If you are going to distribute  
13 free stuff, who is going to distribute it, other-  
14 wise it becomes a free for all. We decided --  
15 my original request was that we first restrict  
16 it to those who were discharged from mental  
17 hospitals. That would give us some information.  
18

19 The second one was whether or  
20 not we should have a means test. My own original  
21 request was to try it out, see what the costs  
22 were going to be and the first, sharpest re-  
23 strictions were, (1) patients who were in mental  
24 hospitals and (2) to be given means tests and  
25 (3) distributed only by accredited psychiatric  
26 clinics or mental hospitals. In other words we  
27 would tie it down. We have seven clinics and  
28 we have hospitals. I suggested at first we try  
29 this out. If we gave it to the general  
30





1 practitioner, you would never know who was getting  
2 it.

3 I wanted to try this out in the  
4 first place and see what the costs were.

5 Then, I was quite sure this would  
6 only be a trial period because as I have said we  
7 just didn't know -- we didn't want to restrict  
8 this to keeping people out of hospital once they  
9 have been in. We would like to prevent them from  
10 getting in in the first place so the families wouldn't  
11 have the stigma of having a patient in the hospital.  
12 There is a stigma. We are trying to get rid of it,  
13 but for the time being it is still in existence.

14 That is a side issue, but neverthe-  
15 less an important one. Since we had no information  
16 on cost this was the first proposal I made to the  
17 Government. I myself would like to try this on an  
18 experimental basis, shall we say, and I would then  
19 like to expand it to giving it to the person who  
20 might be kept out of hospital.

21 THE CHAIRMAN: Who have never been  
22 in?

23 DR. MARSHALL: Yes, who have never  
24 been in. This would be done through a registered  
25 clinic or some other parties.

26 In Nova Scotia, to let you know  
27 how we deal with this, on the various disability  
28  
29  
30



1 pensions we used to have before the new Social  
2 Security scheme went in when people applied for,  
3 say, the old term Mother's Allowance -- the  
4 father is disabled -- where does mental illness  
5 come into the picture? When are you going to give  
6 an allowance?  
7

8 The decision of the Government at  
9 that time was that they would give it to persons  
10 who were psychotic or could be committed. They  
11 wouldn't give it to a patient who was simply a  
12 neurotic or a patient who had a personality dis-  
13 order. These are big problems. Once you get into  
14 the problem of providing -- you get into a very,  
15 very big field where you don't know quite where  
16 it is going to end.

17 These tranquilizing drugs are of  
18 value, not only for your psychotic, but they are  
19 also of great value to the neurotic. Once you  
20 start in the psychotic field, if you start with a  
21 trial case of those who have been in the  
22 hospital, but might be prevented from coming  
23 back to it you would probably get next to the  
24 ones who you think might be prevented from  
25 being admitted in the first place. That would  
26 still be in the psychotic group. Are you  
27 clear about this distinction?  
28

29 Then if you want to go beyond  
30



1 that, the very serious disability illness, the  
2 neurosis, how far the Government will get into  
3 that is still a third problem which could be a  
4 very expensive undertaking, as well as a very  
5 complex one in addition.  
6

7 I was well aware of the problems  
8 involved in this and suggested in order to not  
9 commit the Government too much, to at least start  
10 on the problem of seeing if you couldn't keep  
11 people from being re-admitted, and of course, to  
12 get drugs cheaper and so on.

13 THE CHAIRMAN: You said you had  
14 some rough estimates?

15 DR. MARSHALL: Yes, they weren't  
16 very successful. They weren't satisfactory. I  
17 have forgotten what they were. After I had them  
18 -- afterwards I thought they weren't very good.

19 THE CHAIRMAN: You are still not  
20 satisfied. You wouldn't like to give any figure?

21 DR. MARSHALL: No, I wouldn't.

22 MR. MAC LEOD: Does it follow from  
23 what you have told the Commission that any signifi-  
24 cant lowering of the price of tranquilizers  
25 would assist the Government to put this programme  
26 into operation?  
27

28 DR. MARSHALL: Yes, I would think  
29 it would. I would think not only that, it would  
30



1 help enormously all these people who don't want and  
2 shouldn't ask for Government assistance.

3  
4 This whole business of mental ill-  
5 ness is partly a Government problem, but at the  
6 present stage of our existence it is not entirely.  
7 We are not now in socialized medicine. Many of  
8 these people we see in our clinics -- as I said,  
9 we are shifting our point of emphasis from  
10 hospital care which is just a late stage, to care  
11 right in the community and it would help us at  
12 the hospital end, but it would also help us at the  
13 community end so the patients, they would never  
14 get to our care. That is what I would like to do.

15 THE CHAIRMAN: In the end I sup-  
16 pose you would hope that would not only save a lot  
17 of space, but a lot of money as well?

18 DR. MARSHALL: Sure it would.

19 MR. MAC LEOD: Do you have any ex-  
20 perience, Doctor, in purchasing tranquilizing drugs  
21 under generic names and under brand names?

22 DR. MARSHALL: Yes, we had quite  
23 an experience with that. We originally purchased  
24 under brand names and then we changed from brand  
25 names to the more common and larger used drugs.  
26 Chlorpromazine, we changed from the brand name to  
27 the generic with considerable saving of money.

28 MR. MAC LEOD: What about the  
29  
30



quality of the drug?

DR. MARSHALL: When we did this there was a very great concern -- there was a lot of ideas suggesting the notion that the brand name drugs weren't to be relied...

THE CHAIRMAN: The brand name?

DR. MARSHALL: Yes -- the un-brand name, the generic weren't to be relied on. There were several suggestions that indicated that we would be doing our patients a dis-service if we stopped buying brand names. We weren't too certain about this. We were a bit concerned. Shall we say, there was quite a bit of propaganda, how much was true, how much wasn't true? We wrote to the Dominion Bureau of Statistics to see what information they had, and the information they were able to give us was that the tablets that we were considering getting were -- had in them the amount of material that was specified.

We wrote to the other people who were users of this and we wrote to the Department of National Health and Welfare and the Department of Veterans' Affairs as to what their experience had been. They were using it or trying it out, and we finally did. When we started there were really three suggestions as to whether the ordinary generic name was not satisfactory: (1)





1  
2 that the amounts were not right, (2) that they were  
3 not mixed as well and that the amount of the drug  
4 would vary from tablet to tablet. This was the  
5 proposal as to why we should stick to brand  
6 names in order to be sure you were getting ex-  
7 actly the right dosage.

8 THE CHAIRMAN: Is this a criticism  
9 that they said might be there, or was it what you  
10 found as a fact to be true?

11 DR. MARSHALL: No, this was sug-  
12 gested to us when we were considering the change,  
13 that if you were buying the brand names are so  
14 well established or they were more careful in  
15 their preparations and mixed them better, their  
16 dosage was more reliable, and this was a pro-  
17 posal, a suggestion, a reason as to why we should  
18 stick to brand names rather than move to the  
19 generic names.  
20

21 THE CHAIRMAN: Where would that  
22 suggestion come from?

23 DR. MARSHALL: Apparently they  
24 came from the people who were representing the  
25 brand names.

26 THE CHAIRMAN: Coming from the  
27 manufacturers of these brands themselves?

28 DR. MARSHALL: Yes.

29 THE CHAIRMAN: Did you have any  
30



1 representations from the medical profession?

2 DR. MARSHALL: No. The staff of our  
3 hospitals, like many others were open to the propa-  
4 ganda at the beginning by the brand name people  
5 trying to push their products. Doctors, like every-  
6 body else, are subject to the same impressions.

7 If someone says, "This is good and  
8 this is not.", and you yourself have the life of the  
9 patient at stake, you want to be sure that you are  
10 giving the right things. So we were concerned.

11 The third thing I wanted to say  
12 was that the drugs were said not to be packaged as  
13 well and that they were more fragile and would  
14 break. There was some truth in this last point,  
15 although that has been corrected and the generic  
16 drugs now are packaged as well.

17 Anyway, we tried out small amounts  
18 and as near as we could find out the patients'  
19 end results were as good on the generic as on the  
20 brand names and they were so much cheaper.

21 THE CHAIRMAN: This is chlorpro-  
22 mazine you are speaking about?

23 DR. MARSHALL: Yes, chlorpro-  
24 mazine and as far as our trials were concerned  
25 we could distinguish no difference in the  
26 patients.

27 There was at the beginning a  
28  
29  
30



1 little greater tendency, definitely a greater  
2 tendency for the drugs to be more fragile, to  
3 break up slightly, so that when you order say  
4 1,000 you would find more breakage in this group  
5 than in the trade name product, but the amount  
6 was not very great and you still saved a great  
7 deal of money and in the later products we find  
8 they are no more fragile than any of the others.

9  
10 So that we have stuck pretty  
11 consistently after some misgivings and wondering  
12 ourselves whether there were differences, trying  
13 it out very carefully, to see whether you could  
14 distinguish any difference, and we found that  
15 we could not and so we finally in the case of  
16 chlorpromazine went directly to this, and I may  
17 say that there is a considerable saving.

18 The fact that we used \$65,000.00  
19 worth of tranquilizers, and for chlorpromazine  
20 we spent last year at the price we paid, \$35,000.  
21 00 --

22  
23 THE CHAIRMAN: Is that at the  
24 generic drug price?

25 DR. MARSHALL: I don't know what  
26 the other would be, I think it is somewhere about  
27 half price from the trade name. So we saved a  
28 considerable amount on that which would be very  
29 useful to us. I think we saved enough to finance  
30



1 another mental health community clinic from what  
2 we were able to save on tranquilizing drugs.

3 THE CHAIRMAN: With this particular  
4 drug that you have mentioned, when you buy the  
5 generic name drug, do you get it from any source  
6 territorially? Is it from Europe or the United  
7 States, or do you know?

8 DR. MARSHALL: I am not sure. This  
9 is purchased by the purchasing agent and he is  
10 not in our department. We just order it by that  
11 name and I don't know where he places his orders,  
12 but we are quite satisfied with the amount, the  
13 prices he quotes are less, and we have found they  
14 are more satisfactory.

15 There are other tranquilizers,  
16 other than those and again here you get the same  
17 thing. You get other various forms of anti-  
18 depressants which are not always easy to get by  
19 generic names, and new forms are being produced  
20 constantly.

21 There is an enormous amount of  
22 research being done on this at the present time.  
23 You get a new Company producing a new one, a new  
24 anti-depressant, and you try this one because it  
25 is the only one you have.

26 THE CHAIRMAN: That would be a  
27 trade name.



1  
2 DR. MARSHALL: Yes, it would have to  
3 be. This is the one the research is done on and  
4 this is what produced results, and with this  
5 evidence before you you see if you can cure your  
6 own patients, and you stick to it because it is  
7 all that is available, and we don't have and can-  
8 not afford a larger research testing laboratory  
9 to do this.

10 Then again some of these new ones  
11 may not turn out to be as effective as the ad-  
12 vertisers claim they are, and they are used for  
13 a while and dropped, and another one is found to  
14 be better, and we perhaps eventually settle down  
15 to half a dozen which we consider reliable, but  
16 we always keep our minds open to which of the new  
17 crop we shall try.

18 THE CHAIRMAN: In the course of  
19 time does a generic drug come on the market, of  
20 which these are examples, these trade names?

21 DR. MARSHALL: I would suspect  
22 eventually that will, but at the moment things  
23 are moving so rapidly that the one that has been  
24 out the longest is chlorpromazine and that one  
25 has, but a lot of the others have not yet and  
26 most of the others, as a matter of fact, don't  
27 have such wide use as chlorpromazine.

28 At least in our practice it has  
29  
30





1 been the most widely effective drug. We use it  
2 in large quantities. Others are rather specialized  
3 and are only for certain purposes and are used in  
4 smaller amounts.  
5

6 MR. MAC LEOD: These are all the  
7 questions that I have. If there is any other as-  
8 pect of this field that you think would be of  
9 interest to the Commission, I am sure the Commission  
10 would like to have your views.

11 DR. MARSHALL: No, I think I  
12 have covered pretty much what I think the  
13 Commission wishes to hear about.

14 I view these drugs as one of the  
15 important recent advances in the field of  
16 psychiatry, and if anything can be done to make  
17 them cheaper and more readily available, I think  
18 it would do an enormous amount of good to what I  
19 consider the most serious public health problem  
20 that we have, and I consider this is an extremely  
21 important matter and would hope that some definite  
22 action can be taken.  
23

24 THE CHAIRMAN: Doctor, one more  
25 question on the prices. I am not sure whether  
26 you indicated what the answer would be.

27 Does your Hospital Commission,  
28 the Department of Mental Health, obtain special  
29 prices of trade name drugs or of generic drugs  
30



1 or both or do you know?

2 DR. MARSHALL: I am not too sure.

3 All our purchasing is done by the Provincial  
4 Civil Service Purchasing Agent and we don't actually  
5 come into this at all and I am not too sure what  
6 the prices are on those. I don't know.

7 THE CHAIRMAN: Well, you mentioned  
8 you had been supplied with the different --

9 DR. MARSHALL: Yes, tried  
10 generic name drugs.

11 THE CHAIRMAN: -- with chlorpro-  
12 mazine which you say saved 50 percent.

13 DR. MARSHALL: Yes, as a matter  
14 of fact when we started this was true and at this  
15 point the purchasing commission and the Health  
16 Department were involved in this very closely  
17 because they looked after that. At that time  
18 the people who were selling generic names and  
19 those who were selling brand names came to the  
20 Department of Health, and they came to us and  
21 suggested we could save money. It all came  
22 about because the generic name agents came  
23 to our office and said, "You can save a lot  
24 of money. This is being utilized elsewhere.  
25 It is good stuff.", so we started to enquire  
26 and the figures quoted at that time were very  
27 much less, but what they are at present in  
28  
29  
30



1 relation to the present I don't know because that  
2 comes through the purchasing commission.

3  
4 THE CHAIRMAN: I was wondering,  
5 according to our information at any rate hospitals  
6 and Governments departments and bodies certainly  
7 do not pay the price that a retailer consumer  
8 would pay. They get certain discounts, and I  
9 was wondering whether you knew whether the scale  
10 of discount on trade name drugs was about the  
11 same as it was for generic name drugs or that if  
12 you could give us that information?

13 DR. MARSHALL: I am sorry I can-  
14 not.

15 THE CHAIRMAN: Thank you very much,  
16 Doctor. We appreciate your coming here.

17 MR. MAC LEOD: As far as I know  
18 there are no other witnesses until the pharmacists  
19 tomorrow morning.

20 THE CHAIRMAN: I ask if there is  
21 anybody here who wishes to make any representations  
22 to the Commission this afternoon, because if not  
23 we will adjourn until ten o'clock tomorrow morning  
24 when the Pharmaceutical Association will be re-  
25 presented.

26  
27 MR. MAC LEOD: That is my under-  
28 standing, that they are coming at ten o'clock.

29 THE CHAIRMAN: We will adjourn  
30



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Marshall (MacLeod)

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until ten o'clock tomorrow morning.

---WHEREUPON THE HEARING ADJOURNED UNTIL TEN A.M.  
JULY 11TH.

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--- Upon resuming at 10.00 o'clock

THE CHAIRMAN: Mr. MacLeod?

MR. MACLEOD: Mr. Chairman, I understand Mr. Cox has a presentation to make on behalf of the Nova Scotia Pharmaceutical Society.

THE CHAIRMAN: Would you come around this side, Mr. Cox. There may be questions asked on this so maybe you had better take the box as well as everyone else.

A. WILLIAM COX, sworn

THE CHAIRMAN: Your full name?

MR. COX: A. William Cox.

THE CHAIRMAN: You wish to present a brief?

MR. COX: Yes sir, that is correct.

THE CHAIRMAN: For the Nova Scotia Pharmaceutical Society?

MR. COX: Mr. Chairman, I am appearing in my capacity as solicitor for the Nova Scotia Pharmaceutical Society. I wish to present to the Commission at this time a brief which has been prepared by the Society.





PART I - INTRODUCTION

The Nova Scotia Pharmaceutical Society conscious of its responsibility to the public and to its members, desires to give whatever assistance it can to this investigation. It is not prepared, however, at this time to submit a thoroughly researched and documented submission. The following general material is preliminary only, and the Society would appreciate the opportunity of reserving its right to present a more detailed submission at a later date.

THE CHAIRMAN: I might just clear that point up. Have you in mind a more complete written submission at a later date?

MR. COX: That is correct, sir, or associating ourselves, the Nova Scotia Society with the Canadian Pharmaceutical Society when it presents its brief which it is anticipating so presenting at a later date.

THE CHAIRMAN: Yes.

MR. COX: It is not a request for another verbal submission or hearing. It is a request to submit additional information.

The Society is conscious also of the fact that undoubtedly representations will be made to this Commission by the Canadian Pharmaceutical Association. Members of the Society will probably share in the responsibility for its preparation and will support



1  
2 its presentation.

3           The Society realizes that there are many  
4 people who feel the costs of sickness, including  
5 drugs, a heavy burden to bear. The Society presumes  
6 that the so-called Hall Commission on Health Matters  
7 will study this general field, and that Pharmacy  
8 will be making presentations to that Commission.

9           With these reservations in mind, the  
10 Society makes the following comments for your con-  
11 sideration.

12  
13           PART II - THE ROLE OF PHARMACY

14  
15           "Pharmacy has as its primary object the  
16 service which it can render to the public in safe-  
17 guarding the handling, sale, compounding and dis-  
18 pensing of medicinal substances." That is a  
19 statement taken from the American Pharmaceutical  
20 Code of Ethics.

21           In view of reports that circulate from  
22 time to time via a variety of media, pharmacists  
23 feel that Pharmacy has a story to tell. We are all  
24 familiar with the aphorism "an ounce of prevention  
25 is worth a pound of cure." This is very evident  
26 when we realize that many of the present day medi-  
27 cinals are used as prophylactic measures rather than  
28 as therapeutic agents. The present day practice of  
29 Pharmacy demands that the pharmacist be thoroughly  
30



1  
2 trained in all phases of activity associated with  
3 the manufacture and distribution of medicinals.

4 The pharmacist is charged with the respon-  
5 sibility of translating the Doctor's order into  
6 effective, usable medication. To properly and com-  
7 petently fulfill this function he requires extensive  
8 university training and an extended period of "practical  
9 on the job" training before he is licensed by the  
10 provincial body responsible for the regulation of the  
11 profession of pharmacy.

12  
13 I might say here, sir, the licensing body  
14 here is the Nova Scotia Pharmaceutical Society under  
15 the terms of the Pharmacy Act which is a provincial  
16 statute.

17 The present inquiry into the alleged high  
18 cost of drugs makes it necessary to state certain  
19 facts. In Canada in 1959 it is a known and well  
20 documented fact (H. J. Fuller "Pharmacy In the Canadian  
21 Economy") that of the slightly over half a billion  
22 dollars spent in retail pharmacies 26% was spent for  
23 prescription items at an average cost of only \$2.98  
24 per prescription. This certainly does not indicate  
25 that the public is being exploited in the matter of  
26 charges for pharmaceutical services.

27  
28 It has been said "that the servant is worthy  
29 of his hire." Surely this applies to the pharmacist to  
30 the same degree as it does in other spheres of activity.



1  
2 The reduction in disease mortality rates emphasizes  
3 the "hidden bargain" that is delivered when members  
4 of the public purchase medications prescribed by their  
5 doctors.

6 Increased prices of commodities seems today  
7 to be the rule rather than the exception. It is not  
8 for the Society today to draw lengthy statistical com-  
9 parisons, but the Society is confident that such in-  
10 formation is available to your Commission, and that  
11 it will be most carefully studied by it. When all  
12 factors are taken into consideration, it is submitted  
13 by the Society that any increase in the cost of  
14 services rendered by the pharmacists of Nova Scotia  
15 is in line with the general prevailing increase in  
16 costs of all services and commodities. In addition,  
17 it must be remembered that the effectiveness of both  
18 the products and the services dispensed and given by  
19 the pharmacists have increased tremendously in recent  
20 years.  
21

22 Just in connection with that paragraph I  
23 would like to add here I have a reprint of an article  
24 by Mr. Lawton of the Society. I would like to leave  
25 that with you. That gives some additional information  
26 concerning .....

27 THE CHAIRMAN: Is he an officer of the  
28 Society?

29 MR. COX: He is a member of the Council  
30



1  
2 of the Society and also an officer of the Canadian  
3 Pharmaceutical Association. He gives some inter-  
4 esting figures concerning the increase of costs in  
5 other services during the period which was under  
6 study. If I may I would like to leave that article  
7 with the Commission.

8 THE CHAIRMAN: Thank you very much.

9 The importance of proper and adequate  
10 quality control in the manufacture of drugs cannot  
11 be over-emphasized. Pharmacists are vitally in-  
12 terested in this. Naturally they look to reliable  
13 manufacturers, who exercise reliable quality control,  
14 for their pharmaceutical supplies. Such manufacturers  
15 are prepared and do expend a considerable proportion  
16 of their budgets to assure that the products bearing  
17 their label conform consistently to the highest  
18 possible standards. It is estimated that from 10% to  
19 15% of production cost is spent on these procedures  
20 that assure control of quality. More about this later.  
21 Surely a properly informed public realizing the ex-  
22 istance and value of such rigid controls would not  
23 for an instant sacrifice this guarantee of quality  
24 for price where health, and even life itself, is in-  
25 volved.  
26

27 It takes only a fleeting second to say that  
28 "drug costs are too high", but as you well know,  
29 considerable time and effort are required to delve into  
30 all the procedures that must be laborously gone





1  
2 through before a drug becomes a useful therapeutic  
3 agent. Quality control is much like the air we  
4 breathe. It goes unobserved and is apparent only  
5 when it is lacking.

6           The high regard in which pharmacists are held  
7 in the Nova Scotian community compares favorably with  
8 that enjoyed by members of other professions that also  
9 serve the public well. This regard has developed  
10 because pharmacists believe in the essentiality of  
11 their profession, and because of their conscientious  
12 effort as members of the health team striving to be of  
13 service to their fellow men. This esteem has been  
14 earned through generations of devotion to their  
15 communities and pride in their profession. They are  
16 willing to retain this hard won respect by continuing  
17 to pursue the tenets of professional conduct and  
18 devotion that has characterized the profession in the  
19 past.  
20

21  
22           PART III - BRAND NAME DRUGS

23           A lively controversy exists concerning the  
24 relative merits of physicians prescribing by brand name  
25 or by generic name. The pharmacist finds himself in  
26 the uncomfortable position of being squarely in the  
27 middle of this battle, although through no choice of  
28 his own. He is required by law to dispense prescriptions  
29 exactly as the doctor orders. He has a choice in the  
30



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2 matter only when the doctor prescribes the medicinal  
3 by its generic name. In such a case the pharmacist  
4 may dispense either a brand name drug, or a cheaper  
5 generic drug.

6

7 It is fair to say that at the present time  
8 pharmacists are reluctant to use some of the generic  
9 drugs prepared by little known or unknown manufacturers.  
10 They are not prepared to take unwarranted chances when  
11 the health of the public is concerned.

12

13 It must be remembered that approximately 90%  
14 of the prescriptions dispensed today cannot be pre-  
15 scribed conveniently by generic name because many  
16 prescriptions contain more than one ingredient. Also,  
17 many of the newer drugs in current use are available  
18 only from the manufacturer who developed them.

19

20 The pharmacist' reluctance to accept the  
21 products of little known manufacturers is born out by  
22 many experiences, among which is that of Dr. J. A.  
23 Campbell of the Food and Drug Laboratories, Department  
24 of National Health, Ottawa, in connection with certain  
25 vitamin products. Data accumulated by Dr. Campbell  
26 indicated that "1.5% of controlled vitamin products  
27 produced by ethical drug manufacturers and sold under  
28 brand names were deficient in one vitamin or more.  
29 50% of non-controlled products manufactured by  
30 "cheaper" firms were deficient in one vitamin or more."  
This creates a natural, and almost inevitable suspicion,  
that similar deficiencies may well occur in more



1  
2 potent treatment drugs manufactured by companies  
3 "whose price is better," but who neglect the proper  
4 quality controls, costly though they may be, which  
5 are necessary to protect the public.

6           There is no denying that quality controls  
7 are expensive, and add to the cost of brand name drugs  
8 when sold to the public. The Society cannot help but  
9 feel that any saving of cost by lessening or abandoning  
10 quality controls would be a very poor bargain indeed.

11           As an example of what quality control may  
12 involve we cite information made available by Charles  
13 E. Frosst Company which gives some information of how  
14 demanding in time, effort and money proper quality  
15 control can be. It was estimated by that authority  
16 that to control one batch of a tranquilizing drug 38  
17 employees, 14 departments, 114 operators, 134 tests  
18 and assays, 24 days of work and 31 different raw  
19 materials are required.  
20

21           It cannot be denied that promotion and  
22 advertising costs add to drug prices. Some promotional  
23 and advertising techniques are of questionable value,  
24 but some types of promotional work carried on by  
25 ethical drug manufacturing firms are very beneficial.  
26 These include educational closed-circuit TV for medical  
27 centres, medical teaching funds, research grants,  
28 reprints of medical articles, financing of medical  
29 seminars, the supplying of reliable information to  
30



1  
2 doctors concerning new drugs, and a reasonable amount  
3 of sampling.

4           The Society deplores the excessive sampling  
5 carried on by many manufacturers. It believes this  
6 practice is wasteful and harmful, and when carried  
7 to excess - as regretablely it often is - it adds un-  
8 necessarily to the cost of drugs to the public. There  
9 is also the ever present danger that the excess samples  
10 will be used improperly if they fall into the wrong  
11 hands. The Society feels that indiscriminate sampling  
12 should be regulated and controlled, either voluntarily  
13 by the manufacturers, or compulsorily if necessary.  
14

15           A reduction of present sampling, the keeping  
16 of it within reasonable limits, should not reduce the  
17 effectiveness of the technique, but it could well  
18 result in substantial cost savings and safer use of  
19 the samples by authorized persons only.

20           Why does a physician generally use the brand  
21 name when prescribing for a patient rather than the  
22 generic name? There are probably many reasons, but  
23 just as a patient must have confidence in his physician  
24 so must the physician have confidence in the drug.  
25 The physician therefore generally tends to prescribe  
26 a preparation manufactured by a company well known  
27 to him, and one that he trusts because of its re-  
28 putation and his experience with its products.  
29

30           Many charges have been made alleging that



1  
2 exorbitant profits are being made by the manufactur-  
3 ing drug industry. It is not for the Society, at  
4 this time, to say whether or not these charges are  
5 based on fact or whether they are unfounded. The  
6 Society is confident that the Commission will thor-  
7 oughly examine the great volume of information at  
8 its disposal before coming to any conclusion. The  
9 Society at this time, however, wishes to point out  
10 that under our system of free enterprise a manufac-  
11 turer is entitled to a fair profit. It is the  
12 opportunity to make such a fair profit that serves  
13 as the business incentive. Without such an opportunity  
14 any business would fail to attract talent or capital.  
15 It would stagnate and fail to contribute to the develop-  
16 ment of the medical sciences and the health of our  
17 country.  
18

19           It must also be remembered that the profits  
20 to a large extent provide the capital which enables  
21 the ethical drug manufacturing firms to carry on the  
22 tremendous amount of research which they do. This  
23 research has helped to revolutionize the treatment of  
24 many of our most dreaded diseases by producing the  
25 so called "wonder drugs" in such number in recent years.  
26 The Society doubts that this research could have been  
27 carried on and the tremendous progress made if the  
28 ethical drug manufacturers had not had available for  
29 research the capital created by the profits made on  
30





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the sale of sucessful drugs developed by them.

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The so called "coat-tail riders" who copy ethical firm products sell their imitations at reduced prices, largely because they do not have to recover research costs because they have none, or very little, and because they do not make provision for future research.

If research stopped or was seriously curtailed at the ethical manufacturer's level the Society fears that the recent rapid tempo of progress would be slowed dangerously, and that great harm would result to the public.

#### PART IV - PRICE BOOKS, PRESCRIPTION PRICING GUIDES and PROFESSIONAL FEES.

Experience has shown over the years that for the successful operation of a business - including retail pharmacy - certain conditions must be present. They are, briefly (1) satisfactory sales volume, (2) adequate gross margin of profit, (3) control of expenses, and (4) a reasonable and just net profit. All of these are essential, and it is obvious that an adequate gross margin of profit is no less essential than the other three items. The Society believes that this gross margin can be more conveniently maintained by the use of suggested price catalogues as presently issued by manufacturers and the Canadian Pharmaceutical Journal, and that the use of such catalogues on a



1  
2 voluntary basis does not work to the detriment of the  
3 consumer. In fact we believe that the consumer is  
4 more adequately protected because of the existence  
5 of catalogues than he would be without them since  
6 such publications effectively establish a suggested  
7 maximum price rather than a minimum one.

8           The charges of exorbitant profit making,  
9 while admittedly rarely levelled at retail pharmacy,  
10 serve to give all segments of the industry a bad name.  
11 As retailers, members of the Society, are in the front  
12 line as they deal directly with the consumers. We  
13 therefore feel that comment by the Society at this  
14 time would be appropriate. The Society is not com-  
15 petent to comment on charges that other branches of  
16 the industry make exorbitant profits, and our remarks  
17 in this regard will be confined to conditions in the  
18 retail trade.  
19

20           The average net profit on sales in Maritime  
21 drug stores in 1959 was only 4.9%. This is only  
22 slightly higher than the percentages shown for other  
23 types of retail businesses, and not as high as that  
24 shown for jewellery stores. This figure is not un-  
25 reasonable when viewed in the light of the extra  
26 professional educational training required, the  
27 responsibilities accepted and discharged, and the  
28 extra services given by pharmacists when compared  
29 to other retailers.  
30



Professor Horace Fuller, Professor of  
Pharmacy Administration at the University of Toronto,  
in his survey of 42,454 prescriptions in 1957 showed  
that:

46.3% of prescriptions are priced at \$2.00  
or less

58.8% of prescriptions are priced at \$3.00  
or less

81.7% of prescriptions are priced at \$4.00  
or less

88.6% of prescriptions are priced at \$5.00  
or less

98.9% of prescriptions are priced under  
\$10.00

Only 1.1% of prescriptions dispensed cost  
over \$10.00.

Professor Fuller has also shown that only  
0.81% of total retail trade is spent on prescribed  
medicines. This represents only 0.3783% of the Gross  
National Product. It is therefore difficult to see how  
drug costs can constitute a very serious hardship on  
the Canadian people as a whole.

THE CHAIRMAN: Mr. Cox. just at that  
point with reference to the total retail trade, do  
you know whether that refers to the drug trade of  
druggists or the total trade that they do, because  
some of them sell a great many other things and  
their volume of the other things may be quite large.

MR. COX: That refers to the total  
retail trade in Canada, not only in the retail drug



1

2 industry but the total retail trade of all retailers.

3 THE CHAIRMAN: Of all retailers?

4 MR. COX: That is right.

5 THE CHAIRMAN: All kinds of retailers?

6 MR. COX: That is right, and the next

7 figure is related to the Gross National Product.

8 It is assumed - and it is not seriously  
9 suggested otherwise by responsible people - that the  
10 continued operation of the retail pharmacy is desir-  
11 able, it is obvious that this can only be accomplished  
12 through orderly and efficient business methods on the  
13 part of these pharmacies. It is submitted that the  
14 use of catalogues showing suggested retail prices is  
15 a most convenient and desirable way of maintaining a  
16 fair and reasonable gross margin of profit, not only  
17 for drug stores, but indeed for all retail business.  
18 If publication of such books is eliminated ( and if  
19 they are denied to retail pharmacies it follows that  
20 other retailers would be similarly affected) it is  
21 evident that haphazard and unrealistic pricing will  
22 result, and this could not be to the advantage of  
23 the consumer. It must be strongly emphasized that  
24 this is not advocating price maintenance.

25  
26 It is considered that retail price catalogues  
27 are published for the convenience of the retailer,  
28 that there is no compulsion to use them, and that they  
29 are not in any sense an indication that the pharmacist  
30





1  
2 makes, as a matter of routine, a maximum profit when  
3 a catalogue is used. In fact many pharmacists,  
4 because of small purchasing power, location in re-  
5 lation to source of supply, or through urgent need,  
6 purchase a large part of their supplies from sources  
7 other than manufacturers, and often the prices paid  
8 for these supplies are greater than prices available  
9 from the manufacturer. Because a suggested price  
10 list is in existence the prices shown are taken to be  
11 not only a suggested minimum below which it is un-  
12 economical to sell a product, but also as a suggested  
13 maximum price which the customer might be expected to  
14 pay. The pharmacist is well aware that his colleagues  
15 make use of these lists, and from the standpoint of  
16 being competitive he must sell at the normal price,  
17 and absorb the loss.  
18

19 The situation is muddled by irresponsible  
20 statements made by ill-informed individuals and groups.  
21 It would be highly inappropriate for pharmacist to set  
22 themselves up as authorities in the field of, say,  
23 farm costs and profits. It is just as inappropriate  
24 for spokesmen for agriculture and other associations  
25 to issue inflammatory statements, appealing to the  
26 public's natural antipathy to paying any of the costs  
27 of illness, alleging that the consumer is being  
28 "vastly overcharged" for prescription drugs, and  
29 that there is no competition in the retail drug in-  
30



1  
2 dustry. This is not to say that the Society wishes  
3 to silence anyone. It is merely a request that  
4 suggestions be limited to a sane, sober, and serious  
5 study of the industry aimed at achieving progress,  
6 and not at making headlines or diverting attention  
7 from their own problems closer to home.

8  
9 Simply because retail pharmacists do not  
10 behave as if they were in an oriental bazaar, selling  
11 the same merchandise on the same day at different  
12 prices to different customers the erroneous impression  
13 has grown up - strengthened by irresponsible and ill-  
14 informed statements - that pharmacists do not compete  
15 with one another. If there does not appear to be  
16 price competition in the sale of ethical drugs, it is  
17 because prices are already as low as they can econo-  
18 mically be - at least from the standpoint of the  
19 retailer. Most certainly there is competition in other  
20 fields within the retail drug trade, and it is a good  
21 and healthy sign that the business is keeping pace,  
22 even exceeding progress in other businesses. It is our  
23 opinion that the continued publication of price books  
24 - including that published by the Canadian  
25 Pharmaceutical Journal - is an essential and desirable  
26 practice, and that the consumer as well as the  
27 pharmacist benefits from these publications.

28  
29 Reference is now made to sub-paragraph (7)  
30 of paragraph 183 of the " Statement of Material  
Collected". This is true to some extent, but it



1  
2 should not be taken to mean that all pharmacists  
3 adhere to guides, or that all guides are identical.  
4 In Halifax, for the most part, pharmacists use guides,  
5 but even here there are many exceptions. In Dartmouth,  
6 a different guide is in existence, but not necessarily  
7 adhered to. The pharmacists on the South Shore of  
8 Nova Scotia, to our knowledge, follow no guides or  
9 pattern.

10  
11 While this situation does have an effect on  
12 prescription prices, on the other end of the scale,  
13 Professor Fuller has shown in his survey of 1582 pre-  
14 scriptions in Nova Scotia in 1957 that 48.1% of  
15 prescriptions filled were priced at \$2.00 or under and  
16 were filled at a loss to the pharmacist. It has been  
17 apparent for some time that the prescription departments  
18 of many drug stores are not profit making departments,  
19 and are in fact subsidized by front store operations.  
20 We expect that the submission to be made by the  
21 Canadian Pharmaceutical Association will elaborate  
22 on this point and will provide statistical data to  
23 confirm it.

24 The "Statement of Material Collected" also  
25 includes (without comment) an item regarding pro-  
26 fessional fees. In the past the propriety of a  
27 pharmacist charging such a fee in addition to the price  
28 for the commodity has been questioned. Surely it is  
29 obvious that in normal business practice where services  
30



1  
2 commodities are both involved, that they are treated  
3 separately. If you purchase a bumper for your car,  
4 you pay for it and the garage makes a profit. If  
5 the garage installs the bumper on your car, there is  
6 an extra labour charge which pays for the mechanic's  
7 time, and again the garage makes a profit.

8         Is it unreasonable to apply the same principle  
9 to a pharmacist who requires a college education (now  
10 being extended to four years in the Maritimes), at  
11 least three years practical experience, who is avail-  
12 able at all hours for emergency, who keeps his shop  
13 open extra hours for the convenience of the public,  
14 and who provides many other profitless services for  
15 his customers? This fee which has caused such an  
16 irresponsible uproar by the self appointed though often  
17 ill-informed "watch-dogs" is not in use in many areas.  
18 It is usually 50¢. In isolated areas it is 75¢. This  
19 trifling amount, this "tip", seems to be a source of  
20 irritation, and we can't help but wonder whether it  
21 should be large enough to command respect.  
22

23         It is interesting to note that in areas where  
24 prescription pricing guides are not in use the outcry  
25 is over the variety of prices in different stores for  
26 the same prescription. In areas where suggested  
27 guides are in more or less general use the objection  
28 is to the similarity of prices, and the cry of  
29 "monopoly - no competition" is raised. Pharmacists,  
30



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1  
2 like other business men, are anxious to keep their  
3 customers happy. The Society sincerely feels that  
4 the use of guides establishes an orderly method of  
5 prescription prices. Their use is completely  
6 voluntary and, apart from encouragement to refer to  
7 them as a sound practice (which is, after all, a  
8 duty in the educational service) no pressure is or  
9 can be applied.

10 The Society believes, in all honesty and  
11 sincerity, that prescription pricing guides represent  
12 a fair and reasonable method of pricing prescriptions.  
13 They enable pharmacists to be adequately remunerated  
14 for their services and, more important, they assist  
15 in enabling the public to acquire drugs and medicines  
16 at prices which, as far as retail pharmacists are  
17 concerned, are fair and reasonable.

#### 18 19 20 PART IV - CONCLUSION

21 The Society thanks the Commission for its  
22 kind consideration and hopes that the foregoing will  
23 assist the Commission in its deliberations.

24 It would like, once again, to point out  
25 the incompleteness of this submission and to reserve  
26 its right to make further submissions if it feels  
27 that such would be useful.

28  
29 This submission was prepared by a  
30 Committee of the Council of the Nova Scotia





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2 Pharmaceutical Society, after consultation with the  
3 Society's President. The matters were generally  
4 discussed at the last annual meeting of the Society.

5 All of which is respectfully submitted.

6 Dated at Halifax, Nova Scotia, this 10th.  
7 day of July, A.D. 1961

8

9 (signed) A. William Cox

10 Solicitor for the Nova Scotia  
11 Pharmaceutical Society.

12

13 THE CHAIRMAN: Mr. Cox, would you care  
14 to make any additional comments?

15 MR. COX: No sir, I have no additional  
16 comments at this time.

17 THE CHAIRMAN: There are two points I  
18 would just like to mention. At the bottom of page  
19 1 you refer to

20 "The present enquiry into the alleged  
21 high cost of drugs".

22 MR. COX: That is really an inaccuracy.  
23 It should be into the alleged manufacture and dis-  
24 tribution of drugs.

25 THE CHAIRMAN: It is not the alleged  
26 manufacture.

27 MR. COX: No, I am sorry, the manu-  
28 facture and distribution of drugs.

29 THE CHAIRMAN: We are not concerned  
30



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1  
2 simply with the cost as such.

3 MR. COX: I realize that. That is an  
4 error.

5 THE CHAIRMAN: One other point, I am not  
6 sure how far it was intended to go, where you said  
7 that manufacturers are entitled to make a reasonable  
8 profit, and of course, under the competitive system,  
9 nobody is entitled to make a profit. They are entitled  
10 to try to make a profit, and if they do not succeed,  
11 it is their unfortunate for them. It would make  
12 quite a difference in the approach to prices.

13 I want to make that clear as far as the law  
14 is concerned.

15  
16 I wonder, also, on page 3 where you refer  
17 to Dr. Campbell's statement about the middle of the  
18 page. Have you the date, the approximate date to which  
19 Dr. Campbell was referring at that time?

20 MR. COX: I have not it with me. I can  
21 get it and send it to you.

22 THE CHAIRMAN: I think we would like to  
23 have the approximate time that he was referring to.

24 MR. COX: I will give you the reference  
25 for that.

26 THE CHAIRMAN: And one of the reasons for  
27 that is in recent years we have had a very great in-  
28 crease in the number of prescriptions for an in-  
29 creasing variety of antibiotic and tranquilizer drugs,  
30



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1  
2 the prices of which are much higher than the price  
3 of the older, longer established drugs, and it might  
4 make a difference, the date to which he was referring.

5 MR. COX: Are you referring to the state-  
6 ment of Dr. Campbell or the percentage of retail trade?

7 THE CHAIRMAN: Is the data accumulated  
8 by Dr. Campbell dealing only with vitamin products?

9 MR. COX: That deals only with the  
10 quality of the vitamin products and the control.

11 THE CHAIRMAN: We would just like to have  
12 the date.  
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MR. COX: Percentage of the retail trade,  
I will also get the date for those.

THE CHAIRMAN: We are interested in  
seeing, for instance, whether some of the smaller,  
lesser known drug manufacturers have been improving  
quality as time went along or whether, more or less,  
standing still in relation to the situation and at  
an earlier date.

Mr. MacLeod, have you some questions  
arising out of the brief you would like to ask?

MR. MacLEOD: There is just one point on  
page 8. You developed the argument about fee. It  
is not suggested, I take it, that the fee is charged  
separately, that the man receives so much for drugs  
and store.

MR. COX: No.

MR. MacLEOD: That is the only point I  
wanted.

THE CHAIRMAN: What is suggested is that  
there is a price, suggested price for the product  
and he adds his fee to that in the total that is  
presented to the customer.

MR. COX: That is correct.

THE CHAIRMAN: Mr. Whiteley, I think has  
some questions.

MR. WHITELEY: At the foot of page 5 you  
discuss the net profit of sales in Maritime drug



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1  
2 stores and you then refer to services given  
3 by pharmacists at the foot of that page. Does the  
4 net profit result after taking account of payment  
5 for the services of the pharmacist?

6 MR. COX: It takes account of all services  
7 for which the pharmacist makes a charge. It doesn't  
8 take account of services such as mentioned by Dr.  
9 Reid in his testimony yesterday.

10 MR. WHITELEY: As I recall, Dr. Reid, he  
11 referred to .....

12 MR. COX: Picking up.

13 MR. WHITELEY: Picking up and delivering.  
14 Wouldn't that be a direct expense against the  
15 operation of the business?

16 MR. COX: It is my understanding that the  
17 only charges which are made in the computing of the  
18 4.9% are charges actually taken into account.

19 MR. WHITELEY: If the druggist had a  
20 delivery boy and he took the filled prescription back  
21 to the customer, wouldn't that be a charge against  
22 business?

23 MR. COX: Very often, sir, I understand  
24 these services are provided after hours by the  
25 druggist himself, and, of course, there is no charge  
26 directly made against the item. Those figures are  
27 taken from Professor Fuller's survey. Further detail  
28 would appear in that survey.  
29  
30





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1  
2 THE CHAIRMAN: I suppose it refers then,  
3 Mr. Cox, to the net result after computing all ex-  
4 penses incurred in the operation of the business?

5 MR. COX: That is right.

6 THE CHAIRMAN: But if the druggist or  
7 pharmacist performs some additional work himself  
8 that is not charged up?

9 MR. COX: That is right.

10 THE CHAIRMAN: Would it include a manage-  
11 ment charge or salary for the operator?

12 MR. COX: It would include salary paid to  
13 the manager of the store.

14 THE CHAIRMAN: I am thinking of the owner  
15 operating his own store.

16 MR. COX: Yes sir.

17 THE CHAIRMAN: There was a charge in-  
18 cluded for that and that is the net result after that?

19 MR. COX: Yes.

20 THE CHAIRMAN: Mr. Whiteley? Mr. Carignan?

21 Thank you then, Mr. Cox.

22 Mr. MacLeod, is there anybody else this  
23 morning?

24 MR. MacLEOD: Those are all the witnesses  
25 I know of.

26 THE CHAIRMAN: Is there anybody present  
27 this morning who desires to make any presentation to  
28 the Commission? If not, that will conclude the  
29  
30



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2 hearings here in Halifax.

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4

--- Whereupon the hearings adjourned to Monday, the  
17th of July, 1961, at 10.00 a.m., in Winnipeg,  
at the Law Court Building.

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INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs.

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C. -- Chairman

A.S. WHITELEY, M.A. . . . . Member of the  
Commission

PIERRE CARIGNAN, Q.C. . . . . Member of the  
Commission

F.N. MACLEOD . . . . . Combines Officer,  
representing the Director of Investigation  
and Research

Proceedings of hearings commencing at  
10.10 a.m., Monday, July 17th, 1961,  
et seq, in the City of Winnipeg, in  
the Province of Manitoba.





A/JC/dpw

1  
2 THE CHAIRMAN: I think everyone who is  
3 here knows the purpose of the hearing this morning.  
4 I will just repeat what I have said in other places.

5 This is a hearing before the Restrictive  
6 Trade Practices Commission arising out of an  
7 inquiry into the manufacture, distribution and sale  
8 of drugs in Canada.

9 The Commission is anxious to obtain  
10 as much accurate information as is possible concerning  
11 the various phases of the drug industry. We  
12 have, as a starting point, for our part in the  
13 inquiry a volume of material gathered by the Director  
14 of Investigation and Research under the Combines  
15 Investigation Act, which contains a great deal of  
16 factual information and this is the basis from which  
17 we have begun our stage of the inquiry.

18 It is expected and hoped that organizations  
19 and individuals will provide a great deal of  
20 additional information either confirming, altering or  
21 correcting the facts which have been found or set out  
22 in the volume which we obtained from the Director of  
23 Investigation and Research.

24 That is the purpose of this hearing  
25 this morning; to see what information may be available  
26 in this part of Canada and brought before us.

27 Mr. MacLeod; would you please tell us  
28 who is appearing first?  
29  
30



1 MR. MACLEOD: I believe, Mr. Chairman,  
2 that Dr. Gemmell will appear first.

3 THE CHAIRMAN: Dr. Gemmell, would you  
4 come forward on this side.

5  
6 DR. JOHN PATMORE GEMMELL, sworn

7 MR. MACLEOD: Mr. Chairman, Dr. Gemmell  
8 has a considerable amount of material here. Perhaps  
9 it would be more convenient if he spoke from here.

10 THE CHAIRMAN: I don't think it makes  
11 any real difference. Perhaps we will hear him better.

12 DR. GEMMELL: Yes, I would rather go  
13 back to counsel table.

14  
15 DIRECT EXAMINATION BY MR. MACLEOD:

16 MR. MACLEOD: You are a medical doctor.

17 DR. GEMMELL: Yes sir.

18 MR. MACLEOD: And are you on the staff  
19 of the Faculty of Medicine of the University of Mani-  
20 toba.

21 DR. GEMMELL: Yes.

22 MR. MACLEOD: What is your position on  
23 the staff, Doctor?

24 DR. GEMMELL: I am associate professor  
25 of Medicine.

26 MR. MACLEOD: In association with Dr.  
27 Nickerson, did you prepare an article headed "Doctor:  
28 Drugs and Drug Promotion"?

29 DR. GEMMELL: Yes.  
30



1 MR. MACLEOD: Which was published by  
2 the Canadian Medical Association Journal on April  
3 1st 1959?

4 DR. GEMMELL: That is right.

5 MR. MACLEOD: Now, did you and Dr.  
6 Nickerson make some studies in preparation for this  
7 article?

8 DR. GEMMELL: I think the quick answer  
9 to that is to say formalized studies of analysis of  
10 the particular type of literature would be incorrect  
11 but we have some examples of the medical literature  
12 that we have in advertising that will prove the  
13 point where it is put down in actual numbers and  
14 percent.

15 MR. MACLEOD: Now, Doctor, would you  
16 be prepared to deal with the situation at large, just  
17 to expand on it? I was going to suggest we might  
18 take your article and run through the points that are  
19 mentioned there and to which you could speak?

20 DR. GEMMELL: As you wish.

21 MR. MACLEOD: Well, if you would just  
22 go ahead.

23 DR. GEMMELL: Well, I say - I thought  
24 as the article is available to you that perhaps it  
25 might be of some interest just to alter and to  
26 classify the type of medical advertising that occurs.  
27 Would you agree to that?

28 MR. MACLEOD: Yes.

29  
30



1 DR. GEMMELL: I think, first of all,  
2 there is a certain class with which we are all familiar,  
3 various forms of advertising that other industries use,  
4 to which we are subjected as consumers but it is this  
5 particular thing, advertising directed towards doctors  
6 which we might perhaps classify, just as a broad des-  
7 cription, which is used in the article as "Prestige  
8 Advertising".

9 This is, I think, perhaps of a more  
10 acceptable form of advertising. One of the ways in  
11 which this - you can call it advertising or public  
12 service, if you wish, that the pharmaceutical  
13 industry or component parts of it do is by means of  
14 research, fellowships and student aids and so on.  
15 This is not necessarily specific research but this is  
16 to give help to promising young men. Another type  
17 which is more closely directed towards the medical  
18 profession is primarily educational types.

20 For example, a drug firm sponsoring a  
21 course on a particular disease or diseases, which  
22 are primarily for the education of the physician.

23 The use of closed circuit television  
24 and the use of films or the making of films available  
25 to doctors.

26 These, of course, tend to certainly  
27 advertise the drugs named but often are not neces-  
28 sarily concerned with the firms' products.

29 Along this line - I think this is  
30



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Gemmell, dir  
(MacLeod)

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1 conventional in many industrial practices - they  
2 might subsidize such a thing as dinners at meetings  
3 or cocktail parties and this type of endeavour.

4 Again, in the prestige type of adver-  
5 tising, they may put out special books which are  
6 really mainly directed - and they are in many forms -  
7 these are mainly directed to information. Do you  
8 want me to show this to the Commission?

9 MR. MACLEOD: Yes.

10 DR. GEMMELL: Some of these - you will  
11 find are directed towards a disease but they have  
12 some advertising things in it.

13 Other ones of a similar type are almost  
14 devoid of advertising. It is underwritten by a  
15 pharmaceutical company and is a report of a conference.

16 The other type is sometimes a rather  
17 different educational matter and this is what is sent  
18 out by one pharmaceutical firm about the Kefauver  
19 Committee of which you may be aware.

20 The other type of advertising that  
21 occurs is highly used. I might, if I may, I think  
22 explain this. This is in regular medical journals.

23 THE CHAIRMAN: Doctor, you might iden-  
24 tify these so we will not be confused when we start  
25 to read them over.

26 You have in the last moment or two  
27 handed us three volumes. One is entitled "Metabolic  
28 Effect of Adrenalin Hormones" edited by Dr. Churchill  
29  
30





1 and it is published by Ciba Foundation Study Group,  
2 No. 6.

3 This is one of the types of books that  
4 you believe are mainly informational rather than  
5 simply seeking publicity.

6 DR. GEMMELL: That is right.

7 THE CHAIRMAN: The second one is a  
8 pamphlet entitled "Patterns of Disease" published by  
9 Drug Publications and it is described as "Services  
10 for the Exclusive Use of the Medical Profession".  
11 That is a similar type of publication?

12 DR. GEMMELL: That is right.

13 THE CHAIRMAN: Informational for the  
14 medical profession?

15 DR. GEMMELL: Yes.

16 THE CHAIRMAN: This particular volume  
17 to which we have just referred is entitled "Special  
18 Report on Obesity"?

19 DR. GEMMELL: That is right.

20 THE CHAIRMAN: The third one which you  
21 have handed to us is entitled "Statements presented  
22 to the Kefauver Committee about Steroid Hormones" by  
23 Nobel Laureates, Dr. Edward C. Kendall, Dr. Philip S.  
24 Hench, and Merck officials, John T. Connor and Dr.  
25 Augustus Gibson.

26 DR. GEMMELL: This is rather of a  
27 different nature.

28 THE CHAIRMAN: It is similar in this  
29  
30



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Gemmell, dir  
(MacLeod)

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1 sense: it is mainly informational for use of the  
2 medical profession?

3 DR. GEMMELL: Yes.

4 THE CHAIRMAN: Rather than what you  
5 would ordinarily call publicity directed to adver-  
6 tising?

7 DR. GEMMELL: Yes.

8 THE CHAIRMAN: You have some others?

9 DR. GEMMELL: The next are Medical  
10 Journals. The one I think I can show you here is  
11 the Manitoba Medical Review, which is locally  
12 published and I direct your attention to the adver-  
13 tising in it.

14 THE CHAIRMAN: This is published by  
15 the Manitoba Medical Association itself?

16 DR. GEMMELL: That is right.

17 THE CHAIRMAN: Contains advertising of  
18 various drug companies?

19 DR. GEMMELL: Yes sir. This is the  
20 Canadian Medical Journal and I think the years are  
21 immaterial.

22 THE CHAIRMAN: Published by the Canadian  
23 Medical Association?

24 DR. GEMMELL: Yes.

25 THE CHAIRMAN: This has similar adver-  
26 tising to the one you gave us for Manitoba?

27 DR. GEMMELL: That is right.

28 This is a Journal of the American  
29  
30



1 Medical Association issued on December 20th 1958. I  
2 would like to draw the Commission's attention - there  
3 is approximately 50% of the revenue of the American  
4 Medical Association comes from advertising. I have  
5 no figures for Canada.

6 These are other examples of ones - the  
7 New England Journal of Medicine.

8 THE CHAIRMAN: These journals are to  
9 some substantial extent supported by advertising?

10 DR. GEMMELL: Yes. This is true of  
11 English ones.

12 This is a very reputable journal, the  
13 American Journal of Medicine. I would like to draw  
14 your attention to the fact that this is obviously  
15 very heavily subsidized by advertising.

16 THE CHAIRMAN: Very prettily edited.

17 DR. GEMMELL: Yes.

18 THE CHAIRMAN: Very expensive.

19 DR. GEMMELL: I would just like to, as  
20 an illustration, draw the attention of the Commission  
21 to the clinical advertising in this exceedingly repu-  
22 table scientific journal which is available to many  
23 doctors who are interested in clinical investigation  
24 and the proportion of advertising in it.

25 There are certain journals which I did  
26 not bring. I am sure you may find the medical journals,  
27 very reputable ones of a highly specialized nature,  
28 will contain advertising.  
29  
30



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(MacLeod)

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1 THE CHAIRMAN: But all these journals  
2 you are submitting to us do contain a great deal of  
3 useful information for the medical profession?

4 DR. GEMMELL: In their articles.

5 THE CHAIRMAN: Yes, I am not referring  
6 to the advertising.

7 DR. GEMMELL: The other type of adver-  
8 tising I would like to draw to your attention, which  
9 I may call trade journals, and these journals are  
10 sent to me. These I pay for one way or another.  
11 These are sent to me free of charge.

12 THE CHAIRMAN: The first group you have  
13 mentioned are medical journals published by medical  
14 associations and similar groups?

15 DR. GEMMELL: That is right.

16 THE CHAIRMAN: The present group you  
17 are now coming to, are they published differently?

18 DR. GEMMELL: Yes, I am not familiar  
19 with just exactly who publishes them. Certainly I  
20 receive them free of charge, and without writing for  
21 them.

22 THE CHAIRMAN: This one is described  
23 as, it is called The Canadian Doctor, and is des-  
24 cribed as the business journal for the medical profes-  
25 sion. It is published by the National Business  
26 Publications Limited.

27 DR. GEMMELL: Yes, this is a trade  
28 journal. This is Modern Medicine of Canada which is  
29  
30



1 similar in nature. These two are published by the  
2 same people by the way, or have the same editor any-  
3 way.

4 THE CHAIRMAN: It is published in  
5 English and French at Toronto. I just don't see the  
6 name of the publisher. This next one, the Journal of  
7 Applied Therapeutics, the issue of June 1961. I  
8 don't just see by whom this journal is published. A  
9 publication called M.D.

10 DR. GEMMELL: That certainly originates  
11 in the United States.

12 THE CHAIRMAN: It is described as a  
13 medical news magazine, published monthly by M.D.  
14 Publications Canada Limited.

15 DR. GEMMELL: It is a Canadian edition,  
16 like Time Magazine.

17 THE CHAIRMAN: You are familiar with  
18 that fact?

19 DR. GEMMELL: This is another one, this  
20 is not universally distributed, but it does come to  
21 some people in Canada.

22 THE CHAIRMAN: It is Lippencott's  
23 Medical Science, the issue of May 25th 1961, an  
24 American publication, published by Lippencott.

25 DR. GEMMELL: This is again almost  
26 entirely American.

27 THE CHAIRMAN: American Medical World  
28 News, the issue of June 1961. I see an article  
29  
30





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(MacLeod)

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1 which we may be interested in reading about crack-down  
2 on sale of free samples.

3 DR. GEMMELL: This is another American  
4 one.

5 THE CHAIRMAN: Medical Contribution,  
6 published by Medical Contribution Incorporated, an  
7 American magazine.

8 DR. GEMMELL: These, which are company  
9 journals which are sent out.

10 THE CHAIRMAN: Do you mean by drug  
11 manufacturers?

12 DR. GEMMELL: Yes.

13 THE CHAIRMAN: Here is one by Abbott,  
14 called What is New, issue No. 125 1960, and this one  
15 is Merck, Sharpe and Dome. The Sandos Journal of  
16 Medical Science, that is Sandos the Swiss company,  
17 is it? Here is one by Dr. Gige.

18 DR. GEMMELL: It is published by the  
19 pharmaceutical firm.

20 THE CHAIRMAN: This number about the  
21 North American medical symposium published by Seibert,  
22 the manufacturing company. Bausch and Lomb, Focus,  
23 the Spring issue.

24 DR. GEMMELL: That is really equipment.

25 THE CHAIRMAN: Here is one entitled  
26 The Picto Highlights, and published as a service to  
27 the medical profession, featuring in this issue an  
28 analysis of laboratory results. Here is one  
29  
30



published by I.C.I., Imperial Chemical Industries Limited, in Britain.

DR. GEMMELL: It has very many excellent features about it.

MR. WHITELEY: What would be your general comment on the group that we have just examined. I notice the amount of advertising appears to be limited in nearly all of them.

DR. GEMMELL: Yes, this could be called prestige advertising if you like. One is to sort of publicize the name. It is an endeavour, I think, and this of course is sheer opinion, it is an endeavour to make the medical profession associate, to give if you like a higher opinion of the particular firm, because many of these articles are extremely well published and well done. They are also associated with advertising of one particular company. To be honest, certain of them are quite well done, but you must remember this is only a representative collection, and if you have any ways from fifteen to twenty of these coming into your office, and nowadays there are something like 8,000 medical journals published a month. This is including all languages. There is at least well over 1,000 English literature, plus this mass of material.

THE CHAIRMAN: That, 1,000 a month published in English does not include these company publications?



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1 DR. GEMMELL: No, it does not.

2 THE CHAIRMAN: One more is the Rosch  
3 Medical for the summer, published for Rosch Labora-  
4 tories by International Medical Press. In these  
5 company publications, is the advertising confined to  
6 products of the particular company?

7 DR. GEMMELL: Yes. I will speak a  
8 little later on the direct mail advertising that  
9 comes into the office. I have only a few, because my  
10 secretary throws them away, because she said it makes  
11 me too irritable if I have to open them, and this is  
12 just a few that I picked up. I have an analysis done  
13 by a fourth-year student on the drug direct mail  
14 advertising that came in. This barely warrants  
15 reading.  
16

17 THE CHAIRMAN: Is this last group a set  
18 of circulars dealing with particular drugs?

19 DR. GEMMELL: Particular drugs, or  
20 weather, or whatever you want.

21 THE CHAIRMAN: No, yes, I see, but they  
22 are published by some drug company?

23 DR. GEMMELL: Yes, indeed.

24 THE CHAIRMAN: They start off by saying,  
25 it is called by a number of names. It does not say  
26 that -- it says the Smith, Klein and French Labora-  
27 tories. Specialists' Forecaster, Ciba publishes this  
28 one. And here is one by Roussel Canada Limited. It  
29 is quite a collection.  
30



1 DR. GEMMELL: Perhaps a salutary end  
2 to this, to explain some of our concern, this is the  
3 semi-annual tabulation of the reports submitted to  
4 the, this is the Council of Drugs, the American  
5 Medical Association giving a report on drugs that  
6 have been responsible for toxic effects on the blood.

7 THE CHAIRMAN: Just a list of drugs  
8 which have a toxic effect on blood, it is a very  
9 large number.

10 DR. GEMMELL: Almost every drug. You  
11 may be familiar with this, it is a catalogue, you  
12 may be familiar with its name. Inside there is a  
13 little brochure suggesting a certain type of treat-  
14 ment, which I think it would be fair to say is  
15 generally not acceptable.

16 THE CHAIRMAN: This is a publication  
17 by Jules R. Gilbert, with a brochure inserted. The  
18 issue is May 1961.

19 DR. GEMMELL: Do you want me to hand  
20 all these, or should I just dump them on the table?

21 THE CHAIRMAN: I think we have enough  
22 if you describe them, not all separately, but we  
23 want to get an idea.

24 DR. GEMMELL: These two are given to  
25 our medical students on graduation. You might want  
26 to take a look at these.

27 THE CHAIRMAN: The medical students on  
28 graduation get these from various companies?  
29  
30



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1 DR. GEMMELL: Yes.

2 THE CHAIRMAN: One you handed us is by  
3 Ciba. There are a number of pamphlets and a boxfull  
4 of various kinds of drugs.

5 DR. GEMMELL: The members of the Commis-  
6 sion may like a hundred of these tablets which are  
7 very excellent aspirins.

8 THE CHAIRMAN: This is a P.W. and  
9 Company product containing aspirins?

10 DR. GEMMELL: Yes, I think it is Enperin.

11 THE CHAIRMAN: Is Enperin the same as  
12 aspirin, straight acetylsalicylic acid?

13 DR. GEMMELL: Yes.  
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/BL/dpw

1 THE CHAIRMAN: By Ayerst, another  
2 number of drugs and a catalogue. I get the impres-  
3 sion that the students are not neglected on gradua-  
4 tion, Doctor. And those are from other companies.

5 DR. GEMMELL: Yes. I have made no  
6 effort particularly about doing this. These actually  
7 come from one of our offices, and we have three or  
8 four large packing cases like that; the secretary  
9 just throws the samples in. It may be that we  
10 doctors, I think, as a rule tend to use the samples  
11 perhaps as trials on people; sometimes they save  
12 them for people who can ill-afford medication. It  
13 is given in that way, and in other particular situa-  
14 tions many of us who receive the mail centrally at  
15 the College, there is a box like this, and we take  
16 them and give them to the patients at the out-patients'  
17 pharmacy department.

18 THE CHAIRMAN: Would every student at  
19 graduation get ten or twelve or fifteen of these  
20 boxes of material from various drug companies?

21 DR. GEMMELL: I don't know how many  
22 he would get. But these are given - I just show  
23 these. This starts early. These are representative  
24 of the type of sample advertising that will come to  
25 the doctor. One of the things that is a nuisance is  
26 the fact that it is very often a very large box with  
27 rather little drug in it; certainly not enough in  
28 any one. It is rarely enough to treat a person; it  
29  
30



1 is just enough to start them on, unless you save them.

2 THE CHAIRMAN: It is only intended as a  
3 sample?

4 DR. GEMMELL: Yes.

5 THE CHAIRMAN: Doctor, do samples like  
6 this come not only to students who graduate but to  
7 the medical profession?

8 DR. GEMMELL: These come continually.  
9 If I could read this. This was a study of fourth-  
10 year students associated with the value of drugs,  
11 because one of the students thought it would be of  
12 interest to analyze the direct mail advertising that  
13 comes in. The direct mail advertising received by  
14 the physicians in the Department of Clinical Investi-  
15 gation, Winnipeg General Hospital, was collected  
16 during the last three months of 1959. 200 pieces of  
17 advertising were withdrawn at random. In the case of  
18 exact duplicates, only one copy was used in the study.  
19 The student analyzed it according to his own lights,  
20 and perhaps it may be worth reading this.

21 One of the criteria for evaluation was  
22 product identification. 21.5% failed to state the  
23 official name of the product; indeed, some failed to  
24 state what the drug was at all, it just gave the trade  
25 name.  
26

27 THE CHAIRMAN: You mean they didn't give  
28 the generic name at all?  
29

30 DR. GEMMELL: That is right, or the



1 clinical name, and many of them used the chemical  
2 name which is almost unintelligible except to the  
3 very ultra-specialist in the field. The quality of  
4 the information, according to his opinion, was that  
5 it contained ambiguous statements in 80%, 62% con-  
6 tained statements that were directly misleading,  
7 11.5% contained misleading claims of dose-related  
8 potency (this is a thing that is brought up in our  
9 article), 48% contained no mention of the toxicity  
10 or side effects. The other 37% were limited to  
11 vague generalities, and approximately 15% contained  
12 rather detailed information on toxicity.

13  
14 THE CHAIRMAN: 48% contained no refe-  
15 rence to toxicity, but the fact is that nearly all  
16 of them have some toxic effect?

17 DR. GEMMELL: I think it is fair to  
18 say, isn't it, Dr. Nickerson, that all drugs have  
19 potential toxicity, and this includes patent medi-  
20 cine. That in 95% of cases absolutely no informa-  
21 tion is available on the cost of the drug to the  
22 patient. The type of product advertised was a drug  
23 mixture, not a proper single drug, in 38.5%, and in  
24 his opinion 80% of the advertising, the illustra-  
25 tions, were either irrelevant or in bad taste.

26  
27 THE CHAIRMAN: This was done by one  
28 fourth-year student?

29 DR. GEMMELL: Yes.

30 THE CHAIRMAN: Was there any check



1 made at all to see to what extent it could be relied  
2 on?

3 DR. GEMMELL: No, this was not done. I  
4 know from experience, without going through them - I  
5 have no doubt that these figures are correct. Actually  
6 when you consider that some of these things are quite  
7 objective, there is no reason for him to mislead us.

8 THE CHAIRMAN: It is not a question of  
9 misleading. A fourth-year student's report, it is  
10 not the medical practitioner with ten or fifteen  
11 years' experience.

12 DR. GEMMELL: You don't need to be very  
13 experienced to tell whether a drug is identified or  
14 whether there is a cost on the drug.

15 THE CHAIRMAN: Yes, but do you consi-  
16 der a fourth-year student was qualified to deal with  
17 that completely?

18 DR. GEMMELL: These were brought to  
19 their attention by different staff members. Dr. Nicker-  
20 son brought it to their attention for their opinion,  
21 how they would judge this.

22 THE CHAIRMAN: From your own experience  
23 and knowledge of these matters, you are not surprised  
24 at the results, I take it?

25 DR. GEMMELL: No. I think it is a very  
26 fair analysis of it.

27 So we have talked about drug mail,  
28 direct mail advertising. There are some other things  
29  
30



1 which we should consider.

2 I think perhaps, if I may, at this  
3 moment I might stop embarking on anything else,  
4 unless the Commission would like to ask any ques-  
5 tions of myself or Dr. Nickerson.

6 THE CHAIRMAN: We will have Dr. Nickerson  
7 afterwards.

8 You have given a number of items, some  
9 of which are samples, some were journals, and you  
10 have taken a good many of them from a large carton  
11 on the table. Can you tell me how long it would take  
12 to accumulate samples of literature of that kind like  
13 that?  
14

15 DR. GEMMELL: I have no factual informa-  
16 tion, but I think if you talk to most doctors, you  
17 get one wastepaper basket full a day, if you pile them  
18 all in one wastepaper basket, come reasonably close to  
19 filling it.

20 THE CHAIRMAN: Every day?

21 DR. GEMMELL: Every working day, that is.

22 THE CHAIRMAN: Doctors work seven days a  
23 week.

24 DR. GEMMELL: There are somewhere around  
25 4,500 pieces of direct mail received by the physician  
26 in the United States each year.

27 THE CHAIRMAN: How much?

28 DR. GEMMELL: 4,500.

29 THE CHAIRMAN: 4,500 pieces of direct  
30





1 mail advertising literature per year.

2 DR. GEMMELL: And when you get some of  
3 them this size, they can fill up a wastepaper basket  
4 easily.

5 THE CHAIRMAN: That is in the United  
6 States.

7 DR. GEMMELL: I don't know of any real  
8 study of this that has been done on the exact number,  
9 but I am sure it is not too dissimilar.

10 THE CHAIRMAN: In Canada?

11 DR. GEMMELL: Yes.

12 MR. WHITELEY: In addition to the  
13 material you have put before the Commission, are  
14 there forms of direct mail advertising that don't  
15 include samples?

16 DR. GEMMELL: Oh, yes, there are bro-  
17 chures - there are very few - brochures, blotters,  
18 calendars. I still have a calendar put out by one  
19 large Canadian firm. It has hung in my room ever  
20 since I was a child, because my father was a doctor  
21 and I am very fond of this.

22 MR. WHITELEY: I was thinking more of  
23 promotional material relating to the product.

24 DR. GEMMELL: well, sir, I really think  
25 that this is promotional material. Now, mind you, the  
26 thing is that you cannot - that conventional promotio-  
27 nal material that you would expect to get, say, for  
28 detergents or toothpaste does not reach the doctor's  
29  
30



1 office. This is pitched at a different key, but the  
2 intent of the advertising is no different from what  
3 you see on television. It is just pitched to reach  
4 a particular group, and this group is the doctor.

5 THE CHAIRMAN: The purpose is to sell  
6 the product.

7 DR. GEMMELL: Yes.

8 THE CHAIRMAN: That is what most adver-  
9 tising in a business sense is for.

10 Mr. MacLeod, have you some questions  
11 you would like to ask Dr. Gemmell?

12 MR. MACLEOD: I take it that Dr. Gemmell  
13 has just completed one portion of his evidence.

14 THE CHAIRMAN: Dealing with all these  
15 forms of literature and samples, yes.

16 MR. MACLEOD: I think if it meets the  
17 Commission's approval I prefer to wait until he has  
18 finished and I may have some questions.

19 THE CHAIRMAN: That concludes the ques-  
20 tions we have at the moment.

21 DR. GEMMELL: There is one other thing  
22 that you are aware of, type of advertising, and this  
23 is the direct detailing, detail men employed by  
24 pharmaceutical firms who in certain cases but not all  
25 are trained pharmacists, and they come to the doctor  
26 to explain new products to him to promote his use of  
27 the product of his company. This is direct person to  
28 person advertising. I think it is fair to say that  
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1 he certainly can use up a considerable percentage of  
2 a busy doctor's time unless he is careful; and I  
3 think in his defence in some ways, particularly to  
4 the isolated rural practitioner, he represents a  
5 professional contact which in many cases is a welcome  
6 relief, and I think this must be admitted. Whether  
7 this is the correct type of professional contact for  
8 the isolated doctor is hard to say. But I say again,  
9 as my father was a rural practitioner, and I have met  
10 many of them as a boy with my father, and I still  
11 know them. So it does represent this.  
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D/JC/dpw

1 THE CHAIRMAN: Do you mean by that,  
2 Doctor, that the detail men perform a very useful  
3 function in connection with the practices of rural  
4 practitioners.

5 DR. GEMMELL: I don't know whether it  
6 is useful but it is certainly - it may be of interest  
7 to him. He can talk about things, about medicine  
8 with the detail man who is usually well-versed in  
9 what has happened to some other doctor that he knows  
10 and how so-and-so is doing - professional gossip. I  
11 think professional gossip is part and parcel of every  
12 professional man or any businessman's life.

13 THE CHAIRMAN: I am trying to get at:  
14 what is the value of the information that the detail  
15 man gives to the doctor? Is it more useful to the  
16 country practitioner than it would be to the practi-  
17 tioner in a larger centre where he is in contact  
18 with other members of the profession all the time?  
19 To what extent is it useful?

20 DR. GEMMELL: I would say this, first  
21 of all: their job is to promote the use of their  
22 particular company's products but failing that many  
23 of them, particularly the ones that are trained men  
24 - that are not trained just as salesmen - I think  
25 you can see the advertisements for them, Grade 12  
26 education and so on, these people if they are  
27 trained pharmacists - some of them are, can give  
28 very factual information about the toxicity effects  
29  
30



1 of these drugs. Also I am sure most doctors will  
2 certainly ask the detail men about the cost of this  
3 material.

4 THE CHAIRMAN: Is it your experience  
5 most doctors do ask for the cost? Do you mean, the  
6 cost to the consumer?

7 DR. GEMMELL: That is right. He will  
8 ask it from the detail men. It is not available in  
9 any -- well, I don't think - it is almost - it is  
10 just not available. If you can find examples as to  
11 what the cost of the drug or the suggested retail  
12 price is in this material there, outside of a few  
13 advertisements in the Lancet - this is not available  
14 to the doctor and the only way that the doctor, with  
15 the multitude of drugs, as you are well aware, before  
16 writing the prescription can find out the cost is to  
17 go to the trouble of going to the pharmacist, if he  
18 knows the pharmacist that the person is going to go  
19 to and ask him what he is going to charge for this.

20 There is no list that I can look up of  
21 drugs. They put out -- I am sorry I didn't bring it  
22 -- a thing called The Pharmaceutical Guide which has  
23 lists from many trade name drugs. It is a book so  
24 thick.

25 THE CHAIRMAN: You mean about an inch  
26 thick?

27 DR. GEMMELL: Yes and this contains no  
28 mention of prices whatsoever.  
29  
30





1 MR. MACLEOD: Is that the book?

2 DR. GEMMELL: No, that is not it.

3 THE CHAIRMAN: In regard to the detail  
4 men again, you said some of them were trained pharma-  
5 cists. Do you mean that they are graduates in phar-  
6 macy?

7 DR. GEMMELL: Yes.

8 THE CHAIRMAN: Are you able to say  
9 about what proportion of the detail men would be  
10 trained pharmacists? Is it a small proportion or a  
11 large proportion?

12 DR. GEMMELL: I can say this. It is a  
13 much smaller proportion than it used to be. I think  
14 it is decreasing because you are aware, as well as I  
15 am, that the supply of trained pharmacists is getting  
16 to be rather short.

17 THE CHAIRMAN: Then are some of them  
18 what you would call salesmen, without any training at  
19 all?

20 DR. GEMMELL: They are trained; taken  
21 to the company headquarters and put through a definite  
22 sales course.

23 THE CHAIRMAN: They are trained as  
24 salesmen but they haven't had professional training?

25 DR. GEMMELL: That is right.

26 MR. WHITELEY: These catalogues, which  
27 you gave us, are examples of literary articles that  
28 are sent out by the manufacturers to doctors?  
29  
30



1 DR. GEMMELL: In my experience it is  
2 only - if you want for the sake of a name, the gene-  
3 ric-named ones are the only ones that deliberately  
4 send the catalogues because this is, of course, a  
5 selling point in their promotion. Many of them - I  
6 don't know whether that does - will contain certain  
7 comparative prices in here but there is no one single  
8 book that I can look at. If I would like a drug by  
9 the generic name or by the trade name, there is no  
10 book that I can look up to see what it costs the  
11 patient - none.

12 THE CHAIRMAN: The costs might vary a  
13 little bit because the druggists charge a little  
14 different prices?

15 DR. GEMMELL: Yes, it may even vary  
16 from a manufacturer to manufacturer.

17 THE CHAIRMAN: With regard to this vast  
18 mass of material that comes in to a doctor's office,  
19 are you able to tell us what becomes of it? Do the  
20 doctors attempt to read it - I gather it is impossible  
21 to read it all - what do they do with it? Do they  
22 attempt to go through it pretty carefully?

23 DR. GEMMELL: Well, sir, it is almost  
24 impossible to keep up with even the properly published  
25 literature. Now, mind you, I think one thing about  
26 this material that comes out of the drug houses in  
27 many ways; it is very highly professionalized in its  
28 production. It is almost more attractive sometimes  
29  
30



1 to read even than it is to read articles in the regu-  
2 lar medical journals, and it is particularly so  
3 because even if you look through them, they are  
4 beautifully illustrated, really have been excellently  
5 done.

6 THE CHAIRMAN: That is part of the  
7 business of a good advertising agent.

8 DR. GEMMELL: Yes.

9 THE CHAIRMAN: To produce literature  
10 which is attractive so that people will read it.

11 DR. GEMMELL: Yes but these even in  
12 discussing a disease, in which they may have no  
13 interest, no particular interest, can be very well  
14 done and by well-recognized authorities too.

15 Would you like me to go on?

16 THE CHAIRMAN: Yes.

17 DR. GEMMELL: There are some other  
18 things I think should be brought up perhaps in the  
19 use of drugs.  
20

21 One thing with which I am concerned -  
22 I am not on matters of fact. I am on matters of  
23 opinion - is that I think one of the things that I  
24 personally resent is the fact that the drug compa-  
25 nies or their advertising branches must really consi-  
26 der that we have an exceedingly low sales resistance.  
27 The other thing is that I am equally suspicious that  
28 the salesmen of drug firms have equally low resis-  
29 tance to their advertising managers.  
30



1 I think what happens is they are  
2 talking as to what they think they will do. They  
3 may have an antacid for the stomach and the sales  
4 have dropped. They say "What are we going to do  
5 about it?" "We will promote these sales". So they  
6 spend large sums of money promoting this particular  
7 antacid so its sales go up. Consequently some  
8 other company's sales of antacid go down.

9 THE CHAIRMAN: I think indirectly we  
10 are getting into the field of opinion.

11 DR. GEMMELL: Yes, we certainly are.

12 THE CHAIRMAN: I think perhaps we had  
13 better leave that.

14 DR. GEMMELL: The other one is I would  
15 like to bring up the public responsibility in this.  
16 I do not think this is a matter of opinion. I think  
17 this: the public are increasingly demanding drugs.  
18 I don't think there is any doubt about that.

19 THE CHAIRMAN: They are demanding more  
20 and more drugs.

21 DR. GEMMELL: Yes. I think when a  
22 person comes into a doctor's office he now expects  
23 treatment. If I put it this way to you. If one of  
24 you gentlemen develop a cold or laryngitis you might  
25 call me and say "I have got to have something for  
26 this. I have got to carry on with this Commission".  
27 The correct advice that I would give to you is "Go  
28 to bed and stay in bed. Don't take anything. You  
29  
30



1 will get better".

2 The pressure that you would put on me -  
3 I have to carry on. I have to be able to talk. I  
4 have to carry on with this Commission. My next  
5 meeting is in Regina. I have to be there. "Give me  
6 something". So I will give you some nose drops or  
7 I might give you something that will relieve the  
8 discomfort of the throat.

9 I might worry about giving you some  
10 penicillin in case you feel sick or get an infection.  
11 You might develop a tremendous allergy where there  
12 are nose bleeds and the coating of your tongue will  
13 slough off. You may be in hospital for a month with  
14 a penicillin reaction because you have pressurized  
15 me into prescribing for you. I think this is the  
16 result of what is continuing; a primitive belief in  
17 the magic that occurs with drugs and this magic is  
18 drugs now.

19  
20 THE CHAIRMAN: Has that not been  
21 accelerated by the appearance of the wonder drugs?

22 DR. GEMMELL: The very name "wonder  
23 drugs" is the magic. We do not call them excellent  
24 drugs, which they are. They are called wonder drugs  
25 which means that this brings an element in of the  
26 witch doctor.

27 THE CHAIRMAN: Do I take it from what  
28 you have just said there has been an increase in the  
29 public belief of the efficacy of drugs because of  
30





1 the development in recent years of the very many  
2 excellent drugs?

3 DR. GEMMELL: Yes. I almost feel the  
4 public has transferred its belief in doctors to its  
5 belief in drugs.

6 THE CHAIRMAN: That, of course, will  
7 stay.

8 DR. GEMMELL: Yes, indeed.

9 There is one other matter that I  
10 think should be brought up and that is that I must  
11 confess that I find a great deal of difficulty in  
12 finding any answer to this and this is the responsi-  
13 bility and who bears the cost and who bears the  
14 responsibility of drug trials.

15 If a pharmaceutical company puts a new  
16 drug on the market and after it is released there is  
17 only one way to find out whether it works or not and  
18 that is to try it on people who have an illness.

19 This means that somebody has to try it  
20 and it is not an easy matter. Where do you get the  
21 patients? Who pays the doctor for his time? Who  
22 ensures or designs the experiment so there is no bias  
23 within the experiment? Who ensures that it is carried  
24 out properly?

25 There is no one for it. I think this is  
26 a question that I would prefer that you would direct  
27 to Dr. Nickerson but I think this is a very great  
28 weakness in our particular system.  
29  
30



1 I might add in the United Kingdom  
2 under the Medical Council they have a direct division  
3 of drug trials which may be done in the country on a  
4 nationwide basis.

5 THE CHAIRMAN: What you are telling us,  
6 I gather, is while drug companies in developing a  
7 drug may make a number of experiments to see what the  
8 reaction of the use of the drug is, when it is put on  
9 the market the doctors are on their own to use it or  
10 not to use it.

11 DR. GEMMELL: No sir. The drug is  
12 found in the laboratory and perhaps the common  
13 experimental animal is the laboratory rat and it has  
14 a certain effect which looks like it may be useful in  
15 a certain disease.

17 It is then put through certain toxicity  
18 trials which the Food and Drug people should evaluate.  
19 Then this possibly means it will work in a person  
20 with a disease and then it is released for a clinical  
21 trial to try it on somebody here. The difficulty is  
22 that it is difficult to forecast the toxic effects,  
23 comparing the toxic effects of this drug, comparing  
24 the human with the rat and it is difficult to know  
25 whether the reaction of the human being will be the  
26 same as the laboratory animal.

27 This is before the drug is released  
28 for general use.  
29  
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1 THE CHAIRMAN: But even after it is

2 released for general use, doctors have not too much  
3 assistance in deciding whether it should be used for  
4 a particular case, except their own knowledge?

5 DR. GEMMELL: This use is usually  
6 published in the literature about it.

7 THE CHAIRMAN: This is what they read  
8 in the published literature?

9 DR. GEMMELL: That is right.

10 THE CHAIRMAN: Are there any other  
11 phases of the industry that you would like to des-  
12 scribe or discuss, Doctor? Have you some questions  
13 to ask of Dr. Gemmell, Mr. MacLeod?

14 MR. MACLEOD: You were speaking a  
15 moment ago about literature, Doctor. Is authorita-  
16 tive literature available as quickly as releases  
17 from the drug manufacturers? Does that present any-  
18 thing of a problem?

19 DR. GEMMELL: This is a very difficult  
20 problem. This is brought out, I have just one copy  
21 here. This is an endeavour published in the United  
22 States, and carries no advertising. It is called  
23 the Medical Letter, and is an endeavour to supply  
24 the information on drugs --

25 MR. MACLEOD: This is a comparatively  
26 new publication, is it not, Doctor?

27 DR. GEMMELL: Yes it is.

28 MR. MACLEOD: And I understand there  
29  
30



1 has been some slight criticism of it in the Canadian  
2 Medical Association's Journal?

3 DR. GEMMELL: Dr. Rislow showed, quite  
4 correctly that it is not infallible. There was  
5 really a typographical error appeared in the dose of  
6 a drug, which would have been disastrous, and there  
7 was an error, or more of a misunderstanding in the  
8 use of a combination drug. This was in the treatment  
9 of gout.

10 MR. MACLEOD: Nevertheless, do you feel  
11 that the publication represents an advance and is  
12 helpful on the whole to doctors?

13 DR. GEMMELL: Well, I think, I get it  
14 myself, Dr. Nickerson, will you address this question  
15 to Dr. Nickerson when he comes?

16 MR. MACLEOD: The point I was pursuing,  
17 it was suggested by some doctors who previously gave  
18 evidence before this inquiry, was that the first  
19 source of literature was invariably from drug manu-  
20 facturers, and this would be followed up later by  
21 articles in journals. Is it your experience that is  
22 the case?

23 DR. GEMMELL: If I may put it this way,  
24 that with a very large number of journals it is  
25 impossible for me to keep really on top of these  
26 journals, and therefore -- the information is avail-  
27 able in journals before it is in promotional litera-  
28 ture, but it is impossible to --  
29  
30



1 THE CHAIRMAN: You are saying it is  
2 available in journals before it is available in  
3 promotional literature?

4 DR. GEMMELL: Yes, if you have time to  
5 find it.

6 THE CHAIRMAN: I mean it is there.

7 MR. MACLEOD: Just as a general ques-  
8 tion, we haven't referred in detail to your article  
9 which was included in the material which you submit-  
10 ted to the Commission. Does that article now  
11 reflect your views, or have you modified them in  
12 any way?

13 DR. GEMMELL: Not in the least, except  
14 that I would be inclined to make some of the state-  
15 ments a little stronger.

16 MR. MACLEOD: Your first point is I  
17 think that very few products, despite the ballyhoo  
18 that is associated with their introduction, make  
19 substantial contributions, or are really wonder  
20 drugs.

21 DR. GEMMELL: That is right.

22 MR. MACLEOD: And do you feel that  
23 is so, of the many new drugs and combinations  
24 coming on the market, only a few are really signi-  
25 ficant advances?

26 DR. GEMMELL: That is right.

27 MR. MACLEOD: I think you have covered  
28 pretty well the difficulty of the practitioner in  
29  
30





1 keeping up with the material. A little bit later on  
2 in your article you speak of the imitators. Is it  
3 your experience that when a drug of some significant  
4 value comes on the market, that it is likely to give  
5 rise to a number of imitators?

6 DR. GEMMELL: If it is at all possible  
7 for the chemist to produce it within patent arrange-  
8 ments, which I am not familiar with, and in some  
9 cases in spite of patent regulations.

10 THE CHAIRMAN: You mean it is possible  
11 to form slightly different combinations with a diffe-  
12 rent trade name?

13 DR. GEMMELL: It is identical. For  
14 example, diutel clorthazide is followed closely by  
15 hydrochlorthazide, which is followed again closely  
16 by hydro fluorthazide. There are very many in the  
17 steroid field.

18 THE CHAIRMAN: Those three you have  
19 described have identical uses with practically  
20 identical results?

21 DR. GEMMELL: Yes, the dose may be a  
22 little different, but the result is identical.

23 MR. MACLEOD: What are your opinions  
24 on the use of trade names and generic names in  
25 connection with the sale of drugs?

26 DR. GEMMELL: This is opinion?

27 MR. MACLEOD: Yes, which is more desi-  
28 rable, and for what reasons?  
29  
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1 DR. GEMMELL: I will have to qualify  
2 this statement. The use of the generic name which  
3 is not an easy name, but in my experience it is  
4 becoming easier to remember generic names, but it is  
5 by no means a cure-all. If I am dealing in the  
6 hospital and I am Chairman of the Committee of Phar-  
7 macy and Therapeutics at the Winnipeg General Hospi-  
8 tal, this is done in practice to a certain extent,  
9 and we are trying to make it official as to enable  
10 the pharmacist to substitute chemically identical  
11 things. In other words, if you write a trade name  
12 or a generic name, the pharmacist will use one parti-  
13 cular material.  
14

15 This means then that the pharmacy, and  
16 to a certain extent our Committee have taken the  
17 responsibility of trying to go through the various - I mean  
18 there may be twenty identical drugs offered by twenty  
19 different firms. To try to pick out something between  
20 the most expensive one with a trade name promoted, and  
21 the cheapest one on which we may have no assurance  
22 that this is really manufactured under proper circum-  
23 stances. I would say again, this question of control  
24 of quality of drugs is a field where Dr. Nickerson is  
25 much more qualified than I am. Therefore, in a  
26 controlled field such as a hospital, I am in favour  
27 of allowing generic name drugs to be supplied or  
28 substituted. This goes to the pharmacist, and I have  
29 no assurance as to what brand of drug he will supply.  
30



1 It is then entirely in the pharmacist's hands.

2 THE CHAIRMAN: All he has is the  
3 generic name.

4 DR. GEMMELL: Yes, he may pick the most  
5 expensive one and charge accordingly. He may pick  
6 the cheapest one, on which he has no assurance that  
7 it is properly manufactured or anything. He may  
8 charge cheaper for the cheapest drug. For all I  
9 know, he may give the cheapest and charge the same  
10 as the most expensive. This completely removes from  
11 my hands any sort of quality care.

12 Doctors always say beware the man who  
13 talks of one case, but this will illustrate the  
14 difficulty that you get in. I have a patient who is  
15 entirely dependent on the fact that she receives  
16 cortisone, and this is relatively important, the  
17 amount of the cortisone. My prescription read corti-  
18 sone, which is a generic name, 25 milligrammes, half  
19 a tablet four times a day. Her husband called me  
20 and said she was not well at all, so I put her in  
21 hospital and she was running a high fever and feeling  
22 terrible. I asked if she was taking her medicine and  
23 she said that she was. Obviously she needed more  
24 cortisone, so I gave her intra-venous cortisone and  
25 the minute I did she became a brand new woman.

26 The next morning I asked her where did  
27 you get your cortisone, and she said from the druggist.  
28 I said have you got it with you, and she handed me  
29  
30



1 the thing, and it looked like no cortisone medica-  
2 tion I had ever seen in my life. So I 'phoned the  
3 pharmacist and said: "What kind of cortisone is  
4 this patient getting?". He said: "In the past I  
5 have given her such-and-such a company which is very  
6 reputable, and so-and-so, which is also reputable,  
7 but lately as this is very expensive I have given  
8 her a much cheaper form of drug".

9  
10 It is my opinion, I have no proof, it  
11 is my opinion, the proof satisfies me, that this  
12 didn't contain anything like the amount of cortisone  
13 that it was supposed to, so needless to say that she  
14 is getting, perhaps you want to call it a trade name,  
15 it may be cortisone, such-and-such a company, that I  
16 am sure she is getting the material that I know that  
17 she is getting.

18 THE CHAIRMAN: You wouldn't know whether  
19 that cheaper drug was imported from some European  
20 country?

21 DR. GEMMELL: I would think so, and  
22 the pharmacist thought so, but he was not sure,  
23 because there is no way of telling if you buy it from  
24 a distributor here in Canada, I don't think there is  
25 any way of telling where it is made. I suspect it is  
26 imported, because this identical situation about  
27 cortisone was a subject of a big argument in England,  
28 and this was whether this cortisone is the strength  
29 it is supposed to be. It was a big argument in  
30



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1 literature and letters in the Lancet.

2 Another thing is that the pharmacists  
3 are trying to develop coatings. There is a difference  
4 in Canadian requirements and British requirements, and  
5 he was studying this and put in what we would call a  
6 generic, and this didn't even come close to the speci-  
7 fications, so that this is by no means sure.  
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1 THE CHAIRMAN: Do you find, generally  
2 speaking, Canadian firms have very good quality  
3 control of their drugs?

4 DR. GEMMELL: Yes, I think this is a  
5 general rule, but, as you know, there are some very  
6 reputable drug firms paying out very large sums of  
7 money about difficulty in producing polio vaccine,  
8 and I think there have been other occasions in  
9 which reputable drug firms have made errors.

10 THE CHAIRMAN: This is maybe outside  
11 your field. Do you know whether a number of smaller  
12 drug manufacturers have a high degree of quality  
13 control for the drugs that they manufacture? Maybe  
14 they only manufacture a few drugs.

15 DR. GEMMELL: No, I am not competent to  
16 answer that.

17 THE CHAIRMAN: But, generally speaking,  
18 would this be your position: if you were giving a  
19 prescription to a patient, for reasons of quality  
20 control you would tend to specify a trade name pro-  
21 duct of a manufacturer who you considered to be  
22 reliable?

23 DR. GEMMELL: I would say this is only  
24 applicable in certain very critical drugs, and I  
25 think cortisone, persons whose life depends on an  
26 accurate dose level of this product. Otherwise, if  
27 you came to me for maybe a sleeping pill or antacid  
28 or aspirin, I am sure this is not at all critical.  
29  
30



1 THE CHAIRMAN: Aspirin, being a single  
2 product, it shouldn't be too difficult to produce.

3 DR. GEMMELL: If you get a tablet, a  
4 lot of this tablet is filler and the amount of drug  
5 is very small and therefore there may be variation  
6 in the amount of drug that gets in each tablet.

7 THE CHAIRMAN: Is that true of all  
8 tablets?

9 DR. GEMMELL: It is true of the large  
10 majority.

11 THE CHAIRMAN: Are aspirin tablets  
12 largely filler?

13 DR. GEMMELL: This is five grains or  
14 a third of a gramme.

15 THE CHAIRMAN: I was just thinking of  
16 your illustration of aspirin. Is an aspirin tablet  
17 largely filler?  
18

19 DR. GEMMELL: I would think it is  
20 almost entirely acetylsalicylic acid.

21 THE CHAIRMAN: But it wouldn't be diffi-  
22 cult to manufacture if it is pretty much a single  
23 product?

24 DR. GEMMELL: Yes, but this is a diffe-  
25 rent matter, like dexamethazone, with something like  
26 0.75 milligrammes.

27 THE CHAIRMAN: It is produced under a  
28 form of different names, practically the identical  
29 tablet with various names and various prices.  
30



1 MR. MACLEOD: Are you familiar with the  
2 journal called Clinical Pharmacology and Therapeutics?

3 DR. GEMMELL: No.

4 MR. MACLEOD: In connection with this  
5 matter of generic and trade names, the Director has  
6 included in his statement of material a quote which  
7 appears at page 23 saying that there may be some  
8 danger in the trade names. That is rather contrary  
9 to the position which you take. I would ask you to  
10 look at that, Doctor.

11 DR. GEMMELL: The doctor is Dr. Modell.  
12 I think if I may go back to my student's analysis,  
13 about a fifth of them, from the trade name you didn't  
14 know what was in the drug. I think it is very mis-  
15 leading. I think the doctor is neglecting his duty  
16 if he prescribes a drug and doesn't know what it is.  
17 Prescribing a drug without knowing what is in it is  
18 certainly not to be condoned, and the use of the  
19 trade name is to be frowned on if you don't know what  
20 is in it. Instead of using something like - I am  
21 just selecting at random - something like meticorten,  
22 that is promonozone, it is better to put promonozone.

23 THE CHAIRMAN: In your opinion in many  
24 cases it would be better to use the generic name and  
25 the name of the company whose product you wish to use?  
26

27 MR. MACLEOD: You have described for  
28 the Commission this morning some of the deficiencies  
29 of certain of the drug advertising at least. Do you  
30



1 think that this poses as a real danger in advertising  
2 material circulating to doctors which is inaccurate  
3 or misleading? Do you think it poses a danger?

4 DR. GEMMELL: Well, I think it produces  
5 danger. I think I would like to try in my own mind  
6 to keep some balance in this. I doubt very much that  
7 it is more dangerous than promotion of consumption of  
8 tobacco and alcohol.

9 MR. MACLEOD: I was wondering if you  
10 thought there was any danger of a doctor prescribing  
11 a drug on the basis of information contained in adver-  
12 tising literature that wasn't accurate and, as a  
13 result, perhaps damage the patient?

14 DR. GEMMELL: I think this potential  
15 always exists. If you are prescribing from adver-  
16 tising material there is danger always of this.

17 MR. MACLEOD: Do you run into things  
18 that might be described as a blitz when a new drug  
19 comes out, a very heavy promotional campaign?

20 DR. GEMMELL: Certainly.

21 MR. MACLEOD: In your practice and in  
22 your work in the hospital have you noticed that those  
23 campaigns produce results, that that drug comes into  
24 use fairly rapidly?

25 DR. GEMMELL: This is an opinion. I  
26 think it does. This is true of any new therapeutic.  
27 There is a fashion almost of treating things a certain  
28 way, and this is not only related to drugs, it is  
29  
30



1 even related to procedures, including surgical proce-  
2 dures. I am afraid the pattern of progress of medi-  
3 cine is strewn with straw men who have been promoted  
4 and discarded along the way.

5 MR. MACLEOD: In discussion with the  
6 Chairman a few moments ago you pointed out that the  
7 public demands drugs. Is this reflected in the  
8 writing of a prescription for drugs for which no  
9 prescription is legally required? I may expand on  
10 that. Is it sometimes desirable in order to satisfy  
11 a patient and make them perhaps believe more in the  
12 drug to give them a prescription for a drug rather  
13 than tell them to run down to the drugstore and get  
14 so-and-so?

15 DR. GEMMELL: If you mean do I write a  
16 prescription for acetylsalicylic acid and they take  
17 it instead of going down to, say, Eaton's and get 500  
18 for \$1.98, yes. I must confess I have written pres-  
19 criptions for this, and sometimes for very specific  
20 reasons.

21 THE CHAIRMAN: Sometimes the psycholo-  
22 gical effect on the patient would make you do it, I  
23 suppose?

24 DR. GEMMELL: Well, I think the figure  
25 is as high as 25% of the population, perhaps closer  
26 to 50% of the population, are what are called placebo  
27 reactors, that they will - I would advise you not to  
28 even smile at this, because this is a tremendously  
29  
30





1 important therapeutic thing, this presents terrible  
2 problems. The best example - again I will just  
3 quote and probably dramatize it a little more, but a  
4 friend of mine was evaluating a different type of  
5 treatment in advanced carcinoma of the breast, and I  
6 remember one patient was picked to try this who  
7 required more feeding, approximately every hour, and  
8 this new treatment was tried, and inside of two weeks  
9 she was out, actually going dancing at the nightclub,  
10 because we saw her there. This new treatment had  
11 absolutely no effect on the disease as measured by  
12 radiological progress. This was a placebo effect.  
13 It is a terrible problem to doctors when you are  
14 evaluating new drugs, when you know that 25% of the  
15 people are going to get better no matter what you do  
16 for them.

17  
18 THE CHAIRMAN: If you give them a sugar-  
19 coated pill.

20 DR. GEMMELL: The fancier it is the  
21 better its effect. We tend to associate red drugs  
22 for building blood. There is a great amount of the  
23 primitive in us yet, you know?

24 THE CHAIRMAN: Doctors have to know  
25 that in order to prescribe effectively.

26 DR. GEMMELL: I think you know that  
27 instinctively.

28 MR. MACLEOD: Would there be other  
29 cases where you would be afraid to let the patient  
30



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1 know the name of the drug because he might continue  
2 to dose himself after going out of your care?

3 DR. GEMMELL: There is currently going  
4 on in Lancet in England a very active discussion  
5 about the drugs that people should get should be  
6 labelled, the box should be labelled, and I am in  
7 favour of this. But this produces difficulty when  
8 you start prescribing drugs which will habituate  
9 people, and to use this placebo effect you may change  
10 drugs around. Everybody is familiar with 292's, and  
11 they say these don't seem to be working and you change  
12 them into a different brand of CPC compound. But as  
13 a general rule, I would like to see more drugs labelled,  
14 particularly when I know they are going to take them  
15 continuously.  
16

17 MR. MACLEOD: You discussed some time  
18 ago the question of the detail men. Do you think  
19 there is any real danger of unqualified detail men  
20 giving doctors unreliable information and doctors  
21 acting on it?

22 DR. GEMMELL: My only answer to that,  
23 sir, is that I hope not.

24 MR. MACLEOD: Do you think it is a good  
25 idea from a medical point of view for persons with  
26 perhaps no education suggesting to doctors that they  
27 should use certain products rather than certain other  
28 products?  
29

30 DR. GEMMELL: This is a difficult



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1 question to answer. I would say that I would much  
2 prefer not, that they didn't. I would also say that  
3 I prefer the doctors to realise the source and motiva-  
4 tion behind this type of advertising and judge it  
5 accordingly.

6 MR. MACLEOD: I think those are all  
7 the questions I have.

8 THE CHAIRMAN: Thank you very much,  
9 Doctor.

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JG/dpw

1 DR. MARK NICKERSON, sworn

2 MR. MACLEOD: Mr. Chairman, the press  
3 would like to take a picture of the box with the  
4 doctor. May they take it outside the door?

5 THE CHAIRMAN: If they want to take a  
6 picture of the doctor, if the doctors are willing,  
7 it is all right with us.

8 DIRECT EXAMINATION BY MR. MACLEOD:

9 MR. MACLEOD: You are Dr. Mark Nickerson?  
10

11 DR. NICKERSON: That is right.

12 MR. MACLEOD: You are a medical doctor?

13 DR. NICKERSON: Yes sir.

14 MR. MACLEOD: Also a Doctor of Philosophy?  
15

16 DR. NICKERSON: Yes.

17 MR. MACLEOD: In what subject, Doctor?

18 DR. NICKERSON: Actually my Ph.D. is in  
19 embryology but I have been teaching pharmacology for  
20 the last seventeen years.

21 MR. MACLEOD: You are associated with  
22 the School of Medicine of the University of Manitoba?

23 DR. NICKERSON: Yes. I am Professor  
24 and Head of the Department of Pharmacology and Therapeutics.  
25

26 MR. MACLEOD: You were associated with  
27 Dr. Gemmell in preparing an article which appeared  
28 in the Canadian Medical Association Journal under  
29  
30



1 the title "Doctors, Drugs and Drug Promotion"?

2 DR. NICKERSON: Yes sir.

3 MR. MACLEOD: And just generally, do  
4 you still subscribe to the views which you, in  
5 association with Dr. Gemmell, put forward in that  
6 article?

7 DR. NICKERSON: Yes sir.

8 MR. MACLEOD: Now, it was suggested  
9 we ask you about a couple of points and then if  
10 there is anything else you want to say, Doctor, we  
11 will be very glad to have it.

12 I was asking Dr. Gemmell about the  
13 literature and the time relationship between the  
14 literature published in the Journals and the litera-  
15 ture or promotional material distributed by the  
16 manufacturers. Can you tell us anything about that?

17 DR. NICKERSON: Well, I think I take  
18 a little different point of view than Dr. Gemmell  
19 perhaps because our Department is one of the first  
20 places hit by the promotional literature.

21 Our experience is that the material  
22 from the drug manufacturers almost invariably comes  
23 out before there is reliable clinical material in  
24 the literature that is in the regular medical  
25 journal.

26 The initial brochures that are sent  
27 out very frequently contain references which, if  
28 you look them up, are listed at the end and consist  
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1 entirely of personal communications or papers presen-  
2 ted at some conference; very frequently conferences  
3 held by the drug manufacturer.

4           There is an additional factor which Dr.  
5 Gemmell alluded to and that is the fact that you  
6 very frequently are at a loss to get a full evaluation  
7 of the drug even after a number of papers have been  
8 published.

9           First of all most of the initial publica-  
10 tions in the medical journals are publications by  
11 investigators specifically selected by the drug house  
12 and subsidized by them to a greater or lesser extent.

13           This is necessarily so because the  
14 studies were at least started and often entirely  
15 completed before the drug was available to the medi-  
16 cal profession in general. It is perhaps - I am  
17 speaking from hearsay now - it is fairly general  
18 knowledge, which I think perhaps the members of the  
19 Department have been able to verify on various  
20 instances, that drug houses have a sort of hierarchy  
21 of investigators to whom they initially give the  
22 drug.

23           That is, when a drug house comes out  
24 with a new drug, which is really an advance, you  
25 will find that the initial investigators who  
26 receive it are among the very best investigators on  
27 the Continent.

28           When a drug comes out which is either  
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1 what we refer to as "a me too drug" or of questio-  
2 nable merits, that the initial publications are  
3 usually by people about whom you have never heard  
4 before; so that they select the investigator.

5 Now, particularly in the second cate-  
6 gory, although they are publications, these are  
7 usually quite meaningless. They do not have the  
8 proper control and it is very difficult to evaluate  
9 them.

10 I think the classic example of this  
11 is a survey that the Department made before preparing  
12 our lectures on the subject of tranquilizers two  
13 years ago.

14 This was the question of the use of  
15 what we refer to as minor tranquilizers; things like  
16 meprobamate, in the treatment of anxieties in  
17 patients who are just mildly disturbed. That is not  
18 psychotic.

19 In a survey of something like 200  
20 papers - there is plenty of literature in this field  
21 now - there was no new single paper which convincingly  
22 demonstrated that this tranquilizer would do more  
23 than one of the old-fashioned sedatives like pheno-  
24 barbital for this type of patient. So that in his  
25 practice a doctor would not possibly be able to go  
26 through 200 papers on the subject. I think he is  
27 pretty much dependent on what is said in the promo-  
28 tional literature.  
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1 THE CHAIRMAN: Doctor, you are referring  
2 to the first investigators in a new drug. Were you  
3 thinking of what happened in Canada particularly or  
4 is that in general?

5 DR. NICKERSON: Well, I am generalizing  
6 Canada and the United States together.

7 Up to the present time it is really  
8 quite rare that a new drug is first given to investi-  
9 gators in Canada. The great majority of the new  
10 drugs are brought out by companies who have their  
11 home offices either in the United States or in Swit-  
12 zerland and almost always the investigations are  
13 done in those countries before the drugs are given  
14 to investigators in Canada.  
15

16 I think this is beginning to change.  
17 We have a drug under investigation now which has  
18 not yet been given to investigators in the United  
19 States.

20 MR. MACLEOD: In point of fact it  
21 takes some time for an article to appear in a  
22 medical journal, does it not?

23 DR. NICKERSON: Yes.

24 MR. MACLEOD: It is just the pure  
25 mechanics.

26 DR. NICKERSON: It depends to a large  
27 extent. Shall we say there is an inverse relation-  
28 ship between the speed of publication and the  
29 scientific position of the journal.  
30



1                   There are some of these to which I  
2 refer as promotional journals like Modern Medicine  
3 or Medical Times in which the publications are very  
4 fast and these are, as far as I know, entirely subsi-  
5 dized by the pharmaceutical industry for this purpose.

6                   To get a paper published in a journal,  
7 such as the American Journal of Medicine, to which  
8 Dr. Gemmell referred, takes a minimum of six months  
9 and even nine or ten months so there is quite a delay  
10 in publications.

11                   THE CHAIRMAN: It has been suggested,  
12 Doctor, that only those tests showing what might be  
13 called the spectacular or excellent results are  
14 likely to be published. If the results are mediocre  
15 the tests may be forgotten about and the results  
16 never published.

17                   DR. NICKERSON: This is, I think, true  
18 for two reasons.

19                   One is that the initial studies are  
20 largely supported by the pharmaceutical houses.

21                   If a man starts out with a few bad  
22 results and is obviously not enthusiastic about the  
23 drug, they are not going to push for a completion  
24 of the series.

25                   Sometimes you have to push the inves-  
26 tigator to get the results all completed and  
27 published.

28                   I think another reason rests on the  
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1 physician. It is actually a lot of work to do a  
2 proper clinical trial and to write it up.

3 If the physician is getting some  
4 results which appear to him to be better than he  
5 might obtain from another preparation, he is going  
6 to be very interested in continuing this.

2 7 If he is getting poor results he is  
8 going to be anxious to get those patients out of  
9 the trial and back to some other medication he feels  
10 is beneficial to them, as quickly as possible, so  
11 that I am sure that this occurs.

12 MR. MACLEOD: Now, another point which  
13 Dr. Gemmell suggested we raise with you is the  
14 sources of information for doctors. I think he was  
15 speaking particularly about the information about  
16 list prices and cost to the patient. Can you tell  
17 us something about that, Doctor?

18 DR. NICKERSON: Well, it is my expe-  
19 rience that by and large doctors do not know unless  
20 it is a drug they have prescribed quite regularly  
21 over a period of time - do not really have an  
22 appreciation of what the price is. You can obtain  
23 it from detail men. If you write away or have  
24 the initiative to write to the pharmaceutical houses  
25 I think most of them or all of them have a little  
26 catalogue which lists their prices. Doctors ordina-  
27 rily do not have these available, in my experience,  
28 and I know about one or two instances in which the  
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1 patient almost committed double mayhem on the pharma-  
2 cist and doctor because a prescription was written  
3 and the doctor had read something about a new prepara-  
4 tion and did not realise that a two weeks' supply he  
5 was ordering for the patient cost something in the  
6 neighbourhood of \$50.

7 When the patient got this small box  
8 and the request for the money, I think he almost  
9 tore up the drugstore so that this is a very real  
10 problem.

11 I think that a great deal can be said  
12 for requiring some indication of prices or recommen-  
13 ded prices on a drug. I would very much like to see  
14 something like that.

15 MR. MACLEOD: What about the sources  
16 of information from the other angle, the point of  
17 view of this letter, would you care to say something  
18 about that?  
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DR. NICKERSON: Yes, well, I think

undoubtedly the best source of information is in the actual original data in medical literature. That is, how many cases and in what way, and controlled conditions as compared to something else. Not infrequently these data are not available, at least with the drug's introduction into the market, and with the average practising physician I think we have to recognize that it is simply impossible for them to obtain this. If you recognize that there is one new product per day coming on the market, even when the literature contains all the information, to do thorough search and reach a firm conclusion is a matter of two or three full days of work. In other words, it would be close to impossible, if the physician had nothing else to do except read these. I might state an example that the medical college which is composed of full-time people in the drugs field, we don't think that any one man can keep up with the material. We split them up and one man is particularly responsible for drugs in a basket system, and digested system. I think this has reached the point where no practising physician can evaluate the original literature. The Medical Letter is an attempt by a group of people to do this type of evaluation for the physician. As was brought up earlier, they are not infallible, but in our experience they are infinitely more reliable



1 than any other type of greatly condensed information.  
2 This is exemplified I think by the fact our Depart-  
3 ment felt this was sufficiently important so that we  
4 obtained a subscription to the Medical Letter for  
5 all graduates of this year's class, and I think it  
6 will do them a lot of good.

7 MR. MACLEOD: I have a note about the  
8 testing of drugs. I think that was a discussion of  
9 generic versus trade names?

10 DR. NICKERSON: The matter of quality.

11 MR. MACLEOD: Yes, that was the point  
12 Dr. Gemmell said lays with you?

13 DR. NICKERSON: As Dr. Gemmell indi-  
14 cated, this is a very difficult problem, and from  
15 my own point of view I think there is only one really  
16 satisfactory solution, and that is that we have to  
17 reach a position where any drug that goes on the  
18 market in Canada at least meets certain minimum  
19 specifications. The Canadian Drug Advisory Committee,  
20 of which I am a member, has drawn up with the Food  
21 and Drug Directorate a new set of regulations which  
22 involves recording the source of drugs, imported or  
23 not imported, and specific tests, and I think if the  
24 Food and Drug Directorate, if it did have adequate  
25 resources, or were given the adequate resources to  
26 carry this through, it would give reassurance that  
27 drugs on the market are up to standard, but I can  
28 see no real solution to the generic name promotional  
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1 problem without having some basic assurance of these  
2 minimum specifications.

3 I might say that the difference between,  
4 shall we say the large manufacturers and some of the  
5 smaller producers, is not as great as we sometimes  
6 think. The Medical Letter has done two studies, one  
7 on penicillin and one on prednisone, in which they  
8 went out and bought as many different brand names as  
9 they could at a retail pharmacy, and then had these  
10 analyzed by a laboratory. In the case of prednisone  
11 they obtained samples ranging from \$1.00 to nearly  
12 \$18.00 a hundred tablets. They found only three of  
13 these which didn't meet the official U.S.P. specifi-  
14 cations, and the difference in these three was such  
15 that it would not make any difference to the patient.  
16 So that indicated that there are sub-standard batches  
17 on the market from time to time, they are probably  
18 even today.

19  
20 THE CHAIRMAN: Was this sampling of  
21 trade names only?

22 DR. NICKERSON: No, all the different  
23 suppliers they could get their hands on.

24 THE CHAIRMAN: Including some by gene-  
25 ric name?

26 DR. NICKERSON: Yes.

27 MR. MACLEOD: Are you familiar with  
28 this publication, Clinical Pharmaceutical and Thera-  
29 peutic?  
30



1 DR. NICKERSON: Yes.

2 MR. MACLEOD: Is it a highly regarded  
3 journal in the field?

4 DR. NICKERSON: It is to my mind a  
5 sort of intermediate journal. I would not call it  
6 high-class. I think many people had high hopes for  
7 it when it first came out, but they seem to have  
8 difficulty in getting good manuscripts to fill it  
9 up, and dropped their standards.

10 MR. MACLEOD: Do you know Dr. Walter  
11 Modell?

12 DR. NICKERSON: Yes.

13 MR. MACLEOD: Is he highly regarded?

14 DR. NICKERSON: Yes.

15 MR. MACLEOD: Has his editorial on the  
16 drug explosion, which was in the January 1961 edition  
17 of the magazine, come to your attention?

18 DR. NICKERSON: I noticed it, but I  
19 must say I didn't read it through.

20 MR. MACLEOD: The Dr. Modell we have  
21 been speaking of is the same man who is referred to  
22 in a statement on page 23?

23 DR. NICKERSON: Yes.

24 MR. MACLEOD: Have you had a chance to  
25 look at the excerpt on page 23?

26 DR. NICKERSON: Yes I did.

27 MR. MACLEOD: Do you feel that there  
28 is any danger in the uses of trade names along the  
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1 direction he indicates?

2 DR. NICKERSON: Yes, the point that he  
3 makes is that trade names often don't give any indica-  
4 tion of what type of drug is involved, whereas the  
5 generic name in general gives some indication. I  
6 think this is a point, and that it perhaps might be  
7 worthwhile to stress that if a person is going to,  
8 or does want the product of a particular manufacturer,  
9 there is more advantage in writing the generic name  
10 and then specifying the manufacturer or supplier. I  
11 think there is a reason comes in point on this, in  
12 that a company has recently put out a new drug in  
13 the series, which was the previous example, was  
14 phenylbutazone. This drug is quite effective in a  
15 number of rheumatoid states, but it is also quite a  
16 toxic drug. The trade name for this is Butazoladein.  
17 The generic name, phenylbutazone, the new derivative  
18 is hydrophenylbutazone, but the trade name is Tean-  
19 drill. I couldn't prove this point, but I suspect  
20 this is an attempt to get around many physicians'  
21 concern about the toxicity of the older drug. The  
22 generic name tells you immediately that this is  
23 almost the same thing. The trade name leads you to  
24 think it is not related in any way, nor does the  
25 promotional literature.  
26

27 THE CHAIRMAN: What is the practice  
28 of doctors prescribing here, between trade names  
29 and generic names? Do they give the trade name and  
30



1 the company under the generic name?

2 DR. NICKERSON: I think 90% of the  
3 cases is to write simply the trade name and nothing  
4 else.

5 There are reasons for this, and in an  
6 area which I think some action is indicated, the  
7 generic name, there is no really official procedure  
8 for setting up generic names in Canada. By and  
9 large, the generic names accepted by the Council of  
10 Pharmacy of the American Medical Association is  
11 accepted. The naming of drugs with the numbers  
12 coming up is quite a problem. There are not that  
13 many words in the English language, and it has been  
14 impossible under the terms on which they were working  
15 for this Committee to select generic names. This is  
16 consequently, the legal procedure is to have the  
17 manufacturer submit a trade name and two suggested  
18 generic names. This has become, the selection of  
19 names, quite an argument, and the pharmaceutical  
20 industry, and the art at the moment seems to be to  
21 select a trade name which is catchy and easy to  
22 remember, and to select generic names which are as  
23 difficult as possible to remember.

24 One example which has been on the  
25 market for some little time is Diamox. The generic  
26 name is acetazolamide. Another example is a muscle  
27 relaxer called Flexon. The generic name is zoxazo-  
28 lamine. There seems to be a real attempt to make  
29  
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1 generic names as hard as possible to remember.

2 THE CHAIRMAN: Putting it the other  
3 way, I suppose the trend has been to make the trade  
4 name relatively simple, because that is what they  
5 are going to publicize, and it is easier for people  
6 to understand when it is simple.

7 DR. NICKERSON: That is right. As  
8 you may have heard, one company actually took all  
9 of the syllables from a couple of thousand successful  
10 drugs and ran them through a computer machine in all  
11 possible combinations, and they came out with 75,000  
12 to 85,000 new words. I think they had to edit it,  
13 because some were not nice.

14 MR. MACLEOD: There was some mention  
15 about the supply of pharmacists. Is the number of  
16 people graduating at the pharmacy schools sufficient  
17 to take care of the demand?

18 DR. NICKERSON: I have a very mixed  
19 feeling about this. If you mean if there are enough  
20 that all detail men shall be pharmacists, there are  
21 not enough. If you mean in terms of practising  
22 pharmacists, I think probably from the standpoint  
23 of filling prescriptions, that there are many more  
24 practising pharmacists in big cities than there is  
25 a need for. That is the prescription part is a very  
26 inactive place in a drugstore.

27 MR. MACLEOD: The professional pharma-  
28 cist in the drugstore is doing a great many other  
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1 things than acting as a pharmacist?

2 DR. NICKERSON: I think the majority  
3 of them, the filling of prescriptions is a minor  
4 part of their duties.

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BL/dpw

1 MR. MACLEOD: In your view there is no  
2 danger of the drugstores being short of pharmacists?

3 DR. NICKERSON: I don't see any pros-  
4 pect of that.

5 THE CHAIRMAN: Have you any basis of  
6 forming an opinion as to why the detail men -  
7 difference between detail men inadequately trained  
8 and the matter of the incoming prospects the detail  
9 men have?

10  
11 DR. NICKERSON: I can't really answer  
12 that. I would like to dodge the question by saying  
13 that in my opinion, whether they have a pharmacy  
14 degree or not, the detail man is not a proper man  
15 to be detailing the physician, and if he has phar-  
16 macy training, one of the specific conditions, I  
17 think, of ethical pharmacy is that they should not  
18 prescribe, they should recognize they are not in a  
19 position to determine what drug the patient should  
20 take, and consequently I think it really makes very  
21 little difference, perhaps some but not a major  
22 difference, whether the detail man is a pharmacist  
23 or not. It seems to me, in my experience, and I  
24 have had a good deal, it is what he has been told  
25 at the sales conference, kicking off a campaign on  
26 a new drug or reactivating an old one.

27  
28 MR. MACLEOD: These are the only  
29 points I wanted to raise with you, but if there  
30 are any matters you would like to speak on, please





1 go ahead.

2 DR. NICKERSON: Well, I would like, if  
3 I may, to raise a question that is a little different  
4 than the general line of discussion here.

5 I think there is a feeling in many  
6 circles that drug prices are too high. There is a  
7 feeling in many circles that there is too much drug  
8 advertising and there are too many new drugs intro-  
9 duced. I think we could summarize this whole thing  
10 by saying that the total volume is too big.

11 Now, it seems to me that although the  
12 price of an individual prescription may be an impor-  
13 tant item to an individual, that as far as the health,  
14 if you will, of the community is concerned, the more  
15 important thing is the total drug bill. I think  
16 this is closely tied in with the volume of drug  
17 advertising.

18 Just as an example, I believe that  
19 today or in 1960 the total sales of the adrenal  
20 steroids, cortisone group, in the United States and  
21 Canada was something in the order of \$250,000,000.  
22 Now, I must go into the realm of opinion when I  
23 say that, that I feel personally I am being very  
24 liberal when I say that fifty million of that was  
25 needed.

26 THE CHAIRMAN: 20%, roughly?

27 DR. NICKERSON: Yes. There are other  
28 examples, I think antibiotics are high on the list,  
29  
30



1 where the major percentage is used unnecessarily.

2 I think that the advertising pressure  
3 is a major factor in this, the annual bombardment  
4 with the advertising that gives new life to arthri-  
5 tic patients.

6 Now, there is no question, to follow  
7 up this example, that in a majority of cases an  
8 arthritic who has been having difficulty, if you  
9 give him adrenal steroids he will feel much better  
10 very quickly. There have been some well-controlled  
11 studies in England where they have compared the  
12 adrenal steroids with acetylsalicylic acid, showing  
13 that after two years the ones on the acetylsali-  
14 cylic acid were doing just as well as the ones on  
15 the adrenal steroids, as far as the overall picture  
16 was concerned. I may feel very strong on this point,  
17 because my practice is limited to therapeutic  
18 problems, and I find today one of the biggest  
19 problems is how to get the patients off the adrenal  
20 steroids, because once they have been on them for a  
21 year or two you cannot take them off it because  
22 their own adrenals are compromised. I think here  
23 that the biggest problem - and I don't know that I  
24 have an answer to it - is that this pressure has  
25 brought about an overall gross over-use of drugs.

26 Now, this applies directly to the  
27 advertising, and two items - one specifically has  
28 been mentioned here that I think would be useful in  
29  
30



1 the advertising field, and that is the inclusion of  
2 prices of drugs in the advertising material. A  
3 second point that was strongly recommended by the  
4 Committee on Pharmacy of the Canadian Medical Asso-  
5 ciation just last year was that advertising should  
6 carry an indication, that all advertising should  
7 carry an indication of the toxicity of drugs. That  
8 is by and large available in medical journals and  
9 various places, but it was felt that the practising  
10 physician would benefit more by these if they were  
11 coupled in the material.

12 I think in my own mind that drug  
13 advertising to the physician probably should be  
14 re-evaluated in total. For a long time in both  
15 Canada and the United States there have been quite  
16 strict regulations on drug advertisements to the  
17 lay public because it was felt that they were not  
18 in a position to evaluate themselves the validity  
19 of the claim. Advertising with the physician has  
20 been almost completely unrestricted, even to quite  
21 misleading information, because it was felt that  
22 the physician could stand between the advertising  
23 and the ultimate consumer.

24 I would like to submit that with a  
25 drug a day coming out and with the volume of adver-  
26 tising and journal literature that this is no  
27 longer possible, that the physician cannot stand  
28 between the advertising and the patient, and it may  
29  
30



1 be that the advertising to the physician will have  
2 to be looked at more in the light of the advertising  
3 to the individual who cannot re-evaluate. I don't  
4 mean this to be impinging on the ability of the  
5 medical profession but simply they have been in my  
6 experience quite overwhelmed with the volume with  
7 which they have to cope.

8 THE CHAIRMAN: Has that volume been  
9 increasing rapidly in the last few years?

10 DR. NICKERSON: If you look at a  
11 period over the last 15 years it has been an extremely  
12 large rise. The last figures I saw I think were for  
13 1959, and in that year 396 drugs had been introduced,  
14 which was four less than in the preceding year. So  
15 it may be levelling off, but levelling off at a  
16 point where it doesn't help the physician very much.

17 THE CHAIRMAN: You cannot guarantee it  
18 levelling off?

19 DR. NICKERSON: No.

20 THE CHAIRMAN: A new group of drugs  
21 may affect that?

22 DR. NICKERSON: Yes. It is a minor  
23 manoeuvre.

24 One other point I would like to make  
25 which I think is very important and which has been  
26 partially alluded to here, and that is the basis  
27 for the release of a new drug. Now, at the present  
28 time the terms of reference of the Food and Drug  
29  
30



1 administration is that they are authorized to pass  
2 on toxicity. Many of the people in that organiza-  
3 tion I know realise that this is, in fact, an  
4 impossibility in isolation. We have already  
5 mentioned, and I think it can be said almost unequi-  
6 vocally, that there is no such thing as a non-toxic  
7 drug, when you consider the type of hypersensitivity  
8 that can occur, that any drug can damage. Now, the  
9 level at which you set permissible toxicity I think  
10 can only be determined in parallel with an evalua-  
11 tion of the effectiveness of the drug. If I were  
12 to come up with a drug today which would cure 50%  
13 of the cases of gastric carcinoma but would kill  
14 20% or 30% of the patients who received it, it  
15 still should be passed, because at the moment they  
16 would all die. On the other hand, if I come up  
17 with a drug that more or less did the same things  
18 to stop a running nose, I cannot justify killing  
19 anyone. So it seems to me we have to revise our  
20 overall view of this and provide for a sort of  
21 joint evaluation of toxicity and efficacy to deter-  
22 mine that when a new drug is released it will do  
23 more good than harm.

25 THE CHAIRMAN: Doctor, have you any  
26 suggestions as to how this question of publicity  
27 to the doctors might be handled? It has been  
28 suggested that a hard look might be taken at it in  
29 view of the fact that the doctors are largely  
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1 overwhelmed by the volume and they are not in a posi-  
2 tion to possibly evaluate all the drugs. I think  
3 you couldn't just prohibit all advertising to doctors.

4 DR. NICKERSON: No, I think you can't  
5 do that; I am not sure it would be desirable. Well,  
6 it would be a difficult thing at best. I think in  
7 essence it would amount to doing something similar  
8 to the investigations of toxicity, that is when a  
9 drug is proposed for distribution the manufacturer  
10 or distributor has to present evidence to show under  
11 what conditions it is produced, how much toxicity.  
12 I think it would be at least feasible to develop a  
13 system whereby the claims made by the drug are  
14 subjected to the same thing, that is satisfactory  
15 and controlled evidence that the drug would do this,  
16 that and the other thing.

17  
18 THE CHAIRMAN: With regard to the  
19 suggestions you made for variation in the methods  
20 followed by the Food and Drug branch, do you feel  
21 that these suggestions will assure reasonable accu-  
22 racy of the drug available to the Canadian market?

23 DR. NICKERSON: I feel that they will,  
24 or at least will go a long ways in this direction.  
25 The one thing I don't know about from my own perso-  
26 nal experience is the extent to which the Food and  
27 Drug Director at the moment has the facilities to  
28 carry them out. This might possibly require more  
29 personnel.  
30



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1 THE CHAIRMAN: Do you think you could  
2 say it would be quite impossible to undertake the  
3 thorough testing of every batch of drugs that comes  
4 out on the market?

5 DR. NICKERSON: Yes. This is the  
6 reason the advertising committee made the sugges-  
7 tion, that they will require analytical data, infor-  
8 mation of sources of raw material that went into  
9 the manufacture and provide also, when the Director  
10 feels necessary, for inspection of the facilities,  
11 and although it may still be a lot of work, I  
12 think it is more feasible to check records and ana-  
13 lyse, and so on, than it is to do the actual  
14 testing of all drugs and so on.  
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Nickerson, dir  
(MacLeod)

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THE CHAIRMAN: Doctor, is it your view

that if the Food and Drug Directorate is able to  
put into operation the recommendations that have  
been submitted that you could feel there is good  
quality control of all the drugs from small or large  
companies or companies abroad as well as those in  
Canada so that the generic names could be used more  
freely; that doctors would feel reasonably safe in  
using them?

DR. NICKERSON: This would be my hope  
and anticipation.

THE CHAIRMAN: That is one of the  
main purposes of this proposal?

DR. NICKERSON: Yes, that is the objec-  
tive.

THE CHAIRMAN: Because there is, as  
we have seen this morning, a great deal of hesita-  
tion at least on the part of the medical profession  
to prescribe drugs about which they may have some  
mental reservation as to the sources and therefore  
the quality. Do you feel a good deal of that  
difficulty could be overcome?

DR. NICKERSON: I would expect it  
would. I can recognize this mental reservation  
and it is frequently called to my attention. I am  
frequently asked about this. I am unable to give  
a specific answer as to just what extent the  
particular drug can be relied on.



1 I think at the present time it is very  
2 difficult to give that sort of opinion.

3 I am sure there is more build-up of  
4 scepticism, shall we say, about the quality of drugs  
5 than is actually justified today because the tendency  
6 is when you give a drug to a patient and you do not  
7 get the response you expect from the patient very  
8 often you attribute it to the fact this drug was  
9 from some supplier you did not know.

10 There are very few cases, I think,  
11 comparable to the one Dr. Gemmell mentioned in  
12 which with the patient in hospital with the admini-  
13 stration of another preparation and so on you have  
14 actual evidence of the change in the patient and  
15 consequently good inferential evidence at least  
16 that the drug is at fault. These things are very  
17 rarely controlled.

18  
19 THE CHAIRMAN: Thank you very much,  
20 Doctor.

21 MR. GREGORY: Mr. Chairman, my name  
22 is Gregory. I am appearing here as counsel for  
23 the Manitoba Pharmaceutical Association.

24 Before we break off for the midday  
25 adjournment, if I might ask one indulgence. We  
26 propose to have available for this Commission,  
27 when our brief is dealt with, members of the pharma-  
28 ceutical profession.

29 Unfortunately these gentlemen, with  
30



1 one exception, are practising retail pharmacists.  
2 Under the law of Manitoba they are required that  
3 their place of business have a registered pharma-  
4 cist in attendance at all times during the hours in  
5 which this Commission will be sitting.

6 If we could ascertain at this point  
7 whether we have enough work from other interested  
8 parties to engage us for this afternoon, I will  
9 undertake to have the gentlemen available the first  
10 thing tomorrow morning.

11 If we do not have enough work from  
12 other interested parties to keep us going this  
13 afternoon I would have to arrange to have these  
14 gentlemen made available across the afternoon.

15 THE CHAIRMAN: Perhaps you could  
16 discuss that with Mr. MacLeod, who is arranging  
17 the actual order of appearance. We try to meet  
18 the convenience of people who are appearing as  
19 much as possible but they will not be away too  
20 long from their professional occupation.

21 Perhaps you could discuss it with  
22 Mr. MacLeod and he will tell you what would be the  
23 best time to arrange for the people to appear.

24 MR. GREGORY: Thank you, Mr. Chairman.

25 THE CHAIRMAN: We will adjourn until  
26 2 o'clock.

27 --- The hearing recessed until 2 o'clock.  
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1 --- Upon resuming at 2 p.m.

2  
3 THE CHAIRMAN: Mr. MacLeod, who will  
4 be the next appearance?

5 MR. MACLEOD: Mr. Chairman, we have  
6 Mrs. Moore who has a brief which it might be convenient to take first.

7  
8 THE CHAIRMAN: Mrs. Moore, I understand you are just proposing to read the brief.  
9  
10 You will not be giving any evidence.

11 MRS. MOORE: No.

12 THE CHAIRMAN: It will not be necessary to swear you.  
13  
14

15  
16 MRS. ANDREW MOORE, called:

17 MRS. MOORE: To the Chairman and  
18 members of the Restrictive Trade Practices Commission on the manufacture, distribution and sale of  
19 drugs.  
20

21 I am speaking as President of the  
22 Manitoba Branch of the Canadian Association of  
23 Consumers.

24 The Manitoba Branch of the Canadian  
25 Association of Consumers is profoundly disturbed  
26 by the high cost of drugs to the consumer and  
27 greatly regrets that it is unable to submit a brief  
28 at your hearing in Winnipeg today.

29 At present most of the members of  
30



1 the Manitoba Branch are on holiday and it is not  
2 possible either to prepare a brief or to have it  
3 authorized for submission at this hearing.

4 Such being the case I would like to  
5 ask your forbearance to permit the Manitoba Branch  
6 of the Canadian Association of Consumers to submit  
7 a brief at your next sitting in Winnipeg or, failing  
8 that, through the mail should our Executive so  
9 decide. Should you find it necessary to hold a  
10 second meeting in Winnipeg we shall be most grate-  
11 ful for as much advance notice as possible.

12 Signed as Mrs. Andrew Moore, Presi-  
13 dent of the Manitoba Branch of the Canadian Associa-  
14 tion of Consumers.  
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3 THE CHAIRMAN: Mrs. Moore, it is not  
4 likely that there will be other sittings in Winni-  
5 peg after these hearings are concluded but we will  
6 be glad to receive any written submission or brief  
7 that the Association might like to submit.

8 MRS. MOORE: Thank you very much.

9 THE CHAIRMAN: You might have that  
10 filed.

11 MR. MACLEOD: Yes, Mr. Chairman.

12 I think the next will be representa-  
13 tions to be made on behalf of the Manitoba Govern-  
14 ment. Is there a representative here?

15 THE CHAIRMAN: Is there anybody here  
16 to make the presentation on behalf of the Manitoba  
17 Government or any Department of the Government?

18 MR. MACLEOD: I might say, Mr. Chair-  
19 man, I discussed this with Dr. Johnson's assistant  
20 on the 'phone this morning. I told him I had  
21 thought 2.15 would be about the time that we would  
22 be ready to take him so it is still five minutes  
23 to that time and he told me that a representative  
24 would be here at 2.15.

25 THE CHAIRMAN: Mr. Mackenzie, I  
26 understand you are appearing on behalf of the  
27 Manitoba Government.

28 MR. MACKENZIE: Yes, on behalf of  
29  
30



1 Dr. Johnson, the Minister of Health and Welfare.

2 THE CHAIRMAN: Mr. Mackenzie, will  
3 you be simply reading the brief or will you be  
4 giving some statements and answering questions?

5 MR. MACKENZIE: Mr. Chairman, I am  
6 going to read the brief, if I may, and Mr. Publow,  
7 who is the hospital pharmaceutical consultant to  
8 the Manitoba Hospitals Services Plan will be here  
9 and Mr. Merrett, research economist of the Depart-  
10 ment of Industry and Commerce of the Government  
11 will be here and if there are any questions which  
12 the Commissioners have as to the statements or  
13 facts in the brief, they will be pleased to answer  
14 them.  
15

16 THE CHAIRMAN: What I was going to  
17 say was this: we have adopted the practice and have  
18 been requested to do so, if people are going to  
19 give what may be called evidence, statements of  
20 fact, we have them take the oath. Simply reading  
21 the brief and reading argument perhaps is not so  
22 necessary.

23 MR. MACKENZIE: Yes. Well, I leave  
24 it to you, sir.

25 I am prepared to read the brief, if  
26 you so wish me.

27 This, Mr. Chairman, is Mr. Merrett  
28 and Mr. Publow. May they sit here?

29 THE CHAIRMAN: Yes, surely.  
30



1 I would like to have the full names  
2 of all of those who are appearing for the Manitoba  
3 Government and who are going to be speaking for  
4 the Government and their positions.

5 This submission is not actually signed,  
6 is it?

7 MR. MACKENZIE: No sir.

8 THE CHAIRMAN: I would like to have  
9 the full names.

10 MR. MACKENZIE: My name is Kenneth  
11 Oatway Mackenzie, Deputy Minister of Welfare of the  
12 Province of Manitoba. Mr. Robert Raymond Publow,  
13 consultant to the Manitoba Hospitals Services Plan.  
14 Mr. James Stephen Merrett, research economist,  
15 Department of Industry and Commerce of the Manitoba  
16 Government.

17 THE CHAIRMAN: Yes, Mr. Mackenzie.

18 MR. MACKENZIE: The brief, sir, does  
19 refer to a report of the Joint Committee of the  
20 Manitoba Government and the Manitoba Pharmaceutical  
21 Association and a report of that study. I have  
22 some extra copies which I think we should pass out.

23 THE CHAIRMAN: We shall be very  
24 grateful if you did.

25 MR. MACKENZIE: Shall I proceed?

26 THE CHAIRMAN: Yes.

27 MR. MACKENZIE: INTRODUCTION: The  
28 Government of Manitoba is vitally concerned over  
29  
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1 the high cost of drugs to the people of this Province.  
2 We have several times expressed this concern to the  
3 Federal Government through correspondence with the  
4 Ministers of the Departments of National Health and  
5 Welfare, and Justice. We are therefore more than  
6 pleased that the Restrictive Trade Practices Commis-  
7 sion is undertaking this investigation of the manu-  
8 facture, distribution and sale of drugs in Canada.  
9 We would also like to commend the Commission for  
10 holding these public hearings across Canada to  
11 ensure that all interested parties have an oppor-  
12 tunity to express their views on this vital subject  
13 and we welcome this opportunity to appear before you.  
14

15 The government's current interest in  
16 this investigation of drug prices is a result of two  
17 developments which have occurred in the Province  
18 during the past few years. The first of these is  
19 the significant increase in the direct cost to the  
20 government, and thus to the people of the province,  
21 of the health care which is being extended to our  
22 citizens. The main elements in this increased care  
23 consists of the Manitoba Hospital Insurance Program,  
24 mental hospitals and tuberculosis sanitorias, and  
25 the introduction of the recent Medicare Program to  
26 provide indigents in the province with complete  
27 medical care. The extension of all these services  
28 makes an increasing demand on the financial resources  
29 of the government and the people in this province.  
30



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1 An important part of this increased expense is  
2 higher costs for medication.

3 The second and equally important area  
4 of concern is the apparent increasingly heavy burden  
5 of the cost of drugs and medications to private  
6 individuals in the province. The government is  
7 anxious to secure an examination of the facts in  
8 this connection so that there may be a sound basis  
9 for the development of appropriate public policy.

10 Towards this end the Government has,  
11 on its own initiative in cooperation with the Mani-  
12 toba Pharmaceutical Association, carried out a  
13 study of the retail structure of drug prices in  
14 Manitoba. In this brief therefore, our comments on  
15 the retail section of the drug industry and drug  
16 purchases in hospitals and the cost of drugs for  
17 the Medicare Programme are based on our own expe-  
18 riences. As we have not examined the role of drug  
19 wholesalers and as there are virtually no manufac-  
20 turers in the Province, we are presenting our views  
21 on these two sections of the industry primarily  
22 from the material collected by the Director of  
23 Investigation and Research of the Combines Investi-  
24 gation Act and presented in his study relating to  
25 the manufacture and distribution and sale of drugs.

26 In addition to these areas we would  
27 like to put forward some observations on certain  
28 aspects of the overall operation of the drug  
29  
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1 industry in Canada which perhaps are somewhat out-  
2 side the terms of reference of this Commission as  
3 they do not concern the possibility of trade  
4 restrictions and price collusions. However, we feel  
5 these points are vital to the structure of the  
6 existing industry and should be studied by the Fed-  
7 eral Government to ensure that drugs are available  
8 to the people of Canada at the lowest possible price  
9 consistent with quality.

10 RETAIL

11  
12 When the Medicare segment of our  
13 Social Allowance Program was conceived, the origi-  
14 nal forecast of the cost of drugs to be dispensed  
15 under the program by retail outlets was partially  
16 based on our government's experience with the cost  
17 of purchasing and dispensing drugs and medications  
18 by hospitals and government agencies. In subsequent  
19 discussions with the Manitoba Pharmaceutical Associa-  
20 tion, it was found that based on their experience  
21 the cost of prescribing drugs through retail outlets  
22 would be considerably higher than through hospitals.  
23 This has been proven by the experience of the Medi-  
24 care Program during its first nine months of opera-  
25 tion.

26 During this period, in rural areas of  
27 the province some 26,550 Medicare prescriptions  
28 have been dispensed through retail outlets at a  
29 total cost of approximately \$75,000.00 or an average  
30



1 of \$2.82 per prescription. At the same time in the  
2 City of Winnipeg some 13,659 prescriptions were  
3 dispensed through retail outlets at an approximate  
4 total cost of \$41,400 or \$3.03 per prescription,  
5 about 8% higher in the city than in the country.

6 It is assumed that the difference  
7 between the average prescription price in rural  
8 areas and city outlets is due to a difference in  
9 the prescribing habits of attending physicians, as  
10 pharmacies in both areas use the same prescription  
11 pricing schedule.

12 Also some recipients of Medicare took  
13 prescriptions to hospital pharmacies and the 2,479  
14 prescriptions dispensed by these pharmacies totalled  
15 approximately \$4,092 or \$1.65 per prescription  
16 (\$1.25 basic cost plus a 40¢ administration charge).

17 It is recognized that the cost of dispensing drugs  
18 through hospital pharmacies does not cover the full  
19 overhead and in some cases the sales tax, neverthe-  
20 less, the difference between the cost of the hospi-  
21 tal and the retail outlet of \$1.17 and \$1.38 per  
22 prescription, is in our view most revealing.

23 THE CHAIRMAN: Mr. Mackenzie, refer-  
24 ring to one point in that paragraph, where you  
25 refer to the 2,479 prescriptions dispensed by  
26 hospital pharmacies, you have \$1.65, and in  
27 brackets \$1.25 basic cost plus 40¢ administrative  
28 charges. Does that mean you put 40¢ on every  
29  
30



1 prescription, but the average cost of the prescrip-  
2 tion itself was \$1.25?

3 MR. MACKENZIE: Correct sir.

4 The retail prescription prices quoted  
5 above are based upon the Manitoba Pharmaceutical  
6 Association's suggested pricing schedule less a  
7 discount of 15% and are the lowest prices which the  
8 Pharmaceutical Association considered that its  
9 members could possibly charge and still cover their  
10 costs. Because it was felt that these prices were  
11 very high and that they have been rising in the  
12 past, the Government requested that when for the  
13 first time a province wide programme using public  
14 funds for the provision of drugs through retail  
15 outlets was being established that a coincidental  
16 review of drugs prices should be jointly undertaken  
17 by the Manitoba Pharmaceutical Association and the  
18 Government. Subsequently, the Manitoba Pharmaceu-  
19 tical Association and the Government formed a  
20 joint committee to investigate the price of drugs  
21 in the province. However, because of the fact that  
22 the Pharmaceutical Association is restricted in its  
23 activities to the retail drug industry and could  
24 provide no information other than on the retail  
25 price of drugs and the fact that there is virtually  
26 no drug manufacturing done in the Province of Mani-  
27 toba, in this joint study the prices and markups  
28 on drugs at the retail level only were considered.  
29  
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Copies of the study and its conclusion have been forwarded to the Restrictive Trade Practices Commission in Ottawa, and additional copies are available here for the information of members of this Commission. To summarize this report, it was found that although the remuneration which pharmacists realize is generally greater than that received by owners and proprietors, of any other types of retail outlet, it is felt that this remuneration is not unfair or unreasonable in view of the professional training of the pharmacist and the services he makes available to the community. Also the study established the fact that the average retail markup on prescription drugs in Manitoba is one of the lowest of any province in Canada.

This study and its conclusions, we feel are reasonable for the average retail pharmacy in the province. By this we mean that the study presents a fair and reasonable analysis of the costs of dispensing and pricing in the average community pharmacy that sells prescription drugs as well as a variety of other products; but we do not believe that it answers the following questions:

(a) In total medical care, are the costs of drugs rising out of proportion to other items such as physician's fees, hospital rates, dentist fees, medical insurance? Furthermore, is the total annual per capita expenditure on



1 prescription drugs increasing at a faster or slower  
2 rate than the annual per capita expenditure on these  
3 other items that make up medical care?

4 (b) Is the present method of the  
5 retail distribution of drugs reasonably economic in  
6 all circumstances peculiar to the drug trade? (The  
7 possibility that savings may be realized from a  
8 larger pure dispensary are suggested in the material  
9 collected by the Investigation Section of the  
10 Combines Investigation Act. In Table XII, of their  
11 report "Average cost of profits of pharmacies repor-  
12 ting prescription sales, 1959" (page 75) it is shown  
13 that in the larger dispensaries of pharmacies total  
14 expenses are down and profits are up when those  
15 pharmacies dispense over 40% of their total receipts  
16 in prescriptions. The observation made on this fact  
17 on page 74 of the report is, "while the average sales  
18 of those pharmacies reporting prescription sales as  
19 10 to 20% of total sales were subsequently higher  
20 than those reporting prescription receipts over 40%  
21 of total sale cost, there was a decrease in total  
22 expense as prescription sales increased sufficient  
23 to make the total income of the pharmacies selling a  
24 higher proportion of prescriptions greater than that  
25 of pharmacies selling an average of fewer prescrip-  
26 tions".)

27  
28 (c) What changes in the structure of  
29 the retail drug trade would promote more economical  
30



methods of distribution to the public.

(d) Does the endorsement of pricing schedules by the Provincial Pharmaceutical Association tend to hinder the development of the larger pure dispensaries with an associated possible price saving to the consumer, and does it foster the continuation of the small community outlet with its relatively higher cost of operation?

GOVERNMENT

1. Cost of prescription in hospitals:

As was referred to earlier, a study of the costs of Medicare prescriptions paid for by the Government has revealed a substantial difference between the prices of prescriptions dispensed by hospitals and retail drug stores in the province. The reasons for these price differences are primarily a result of purchasing privileges peculiar to hospitals which are not available to the retail pharmacists and to a lesser extent cost savings resulting from large bulk purchases and the pure dispensary nature of the hospital pharmacy which are available to a retail pharmacist if his volume is sufficiently large. The factors which are peculiar to a hospital dispensary are as follows:

(a) The hospital pharmacy does not pay a sales tax on the drugs they purchase which gives them an approximate saving of approximately 7% on cost price.



1 (b) The administration charge of 40¢  
2 per "Medicare" prescription reflects only direct  
3 costs and does not include any indirect expenses.

4 (c) The hospital pharmacy receives  
5 many discount privileges from manufactures which  
6 are not normally extended to the retailer.

7 (d) In some instances, where the  
8 volume of a particular drug is sufficiently large  
9 and the hospital policy permits it, our experience  
10 in Manitoba has revealed that hospitals can realize  
11 substantial savings by tender call and competitive  
12 bidding by suppliers.

13 In addition to the above savings, the  
14 hospital pharmacy can take advantage of some addi-  
15 tional savings resulting from the volume of drugs  
16 which they dispense. These savings would be avail-  
17 able to the retail pharmacist if he were able to  
18 enjoy a similar volume of prescription business.  
19 These are as follows:

20  
21 (a) Certain cost savings are avail-  
22 able to any customer who purchases in bulk quan-  
23 tity from a drug manufacturer or wholesaler.

24 (b) The average hospital pharmacy  
25 because of volume dispensing is able to maintain a  
26 smaller and hence less expensive inventory in  
27 relation to the volume of drugs dispensed.

28 Although data is not available on  
29 which to determine the proportion of the average  
30



price difference of \$1.17 and \$1.38 between prescriptions dispensed under the "Medicare" program from hospitals and retail outlets, nevertheless, it is felt that some of this difference, results from the savings obtained by hospital pharmacies from bulk purchases and inventories. It is suggested that some of this saving could be made by large retail pure dispensaries.

2. Variations in tenders to Government agencies:

Although as we have shown there is a substantial cost saving in hospital over retail purchasing of drugs, our experience in prices quoted by manufacturers on Provincial Government tenders for drugs has revealed a price variation between manufacturing firms for equal quantities of the same type of drugs of up to 491%. These price discrepancies occurred in a recent tender call for drugs by generic names for use in mental hospitals in the province, the quotations between high and low bidders for drugs were 194%, 221%, 279%, and 491%. The prices quoted by these companies and the variation are shown in the following table.

THE CHAIRMAN: You have companies 1, 2, 3, 4, 5, 6, 7 and 8. Are the companies 1, 2, 3 and 4 the same companies for each type of drug?

MR. MACKENZIE: No, they are not.

THE CHAIRMAN: I don't think it is





necessary, unless you have some comments to make about it.

MR. MACKENZIE: No, I think the table is self-explanatory.

Variation in Price Quotations by Different  
Manufacturing Firms for the Same  
Quantities of the Same Drugs

				Per cent difference between highest and lowest prices quoted
Drug	Company	Price Quoted		
A	1	\$140	)	
	2	154	)	
	3	204	)	
	4	208	)	
	5	240	)	491%
	6	320	)	
	7	368	)	
	8	828	)	
B	1	220	)	
	2	718	)	279%
	3	834	)	
C	1	126	)	
	2	295	)	
	3	360	)	221%
	4	405	)	
D	1	384	)	
	2	1128	)	194%
	3	1128	)	



1                   We would suggest the price differences  
2   noted above which are charged by different manufac-  
3   turers for the same drugs indicates that the manufac-  
4   turer must bear some responsibility for the high and  
5   rising cost of drugs. Hospital and institutional  
6   pharmacies may take advantage of the different prices  
7   quoted by various manufacturers to obtain the best  
8   quality product at the best price. However, private  
9   retail pharmacies must accept specific drugs at  
10   specific prices and we feel often must purchase  
11   drugs at very high prices.

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WHOLESALE

There are only three major wholesalers operating in the Province of Manitoba. The proportion of drugs in the province handled by wholesalers is not known, but an analysis of their prices and discounts in comparison with the prices and discounts of manufacturers who distribute their own drugs indicates that they are competitive. Although we have no data on the financial operation of drug wholesalers in this Province, Table XIX on page 81 of the material collected by the Investigation and Research Branch of the Combines Investigation Act appears to bear out the supposition that Canadian Drug Wholesalers are making a very modest rate of profit.

MANUFACTURING

Although as stated previously there is virtually no manufacturing of drugs in Manitoba, nevertheless, we have some comments to make on this area of your investigation. On reviewing the material collected by the Director of Investigation and Research of the Combines Investigation Act for this Inquiry Relating to the manufacture, distribution and sale of drugs, it was apparent that several areas required closer scrutiny with some positive recommendations to reduce the cost of medications. We suggest that the areas needing a more critical analysis are:



1. Promotion.
2. Research and Quality Control.
3. Patents.

Table XXIV on pages 108, 109, 110 of the material collected for this inquiry reveals that the promotion of drugs by one manufacturer is as high as 51.55% of the sales dollar. This we believe is one vital reason for the existing condition whereby Canadian citizens pay close to the highest prices in the world for their drugs.

Several statements contained on pages 115 - 118 inclusive of this report bear out the assumption that the promotion of drugs is one of the major reasons for this high cost, to quote from your report:

"The average for all the firms from which information on this point was obtained was almost precisely 25 per cent (actually 24.93%)..... It was possible to calculate the cost of goods sold as 36.21% of net sales. If two firms which, because of the nature of their operations, have relatively high costs of goods sold, are taken out, the average for the remaining 22 firms is 33.38%. Thus the cost of advertising and promotions is one of the major expenses of doing business and is, of course, reflected in the prices charged for the products sold. There was a wide variation in the expenditures reported by particular firms but the figures



1 show, and this is a matter of common knowledge, that  
2 the large ethical drug firms spend proportionately  
3 more than do small firms".

4 What with the rapid development in  
5 the drug field, we are in sympathy with the pharma-  
6 ceutical manufacturers in their problem of dissemi-  
7 nating information about new drugs and new findings  
8 about old drugs. As stated in a press report in  
9 the Vancouver Sun of March 24, 1960: "A Drug  
10 Company executive said here today there is no way  
11 to avoid the high cost of promoting new drugs".

12 However, we believe that in many  
13 instances the cost of such promotion has gone  
14 beyond all reason. To quote further from your  
15 report and the statement made by John T. Connor,  
16 President of Merck & Co. which appeared in Newsweek  
17 on May 16, 1960: "Connor has admitted, and most  
18 other drug manufacturers agree privately, that  
19 promotion expenses - the huge volume of direct mail  
20 advertising to doctors, visits by detail (promotion)  
21 men, and extensive advertising in medical journals  
22 - have gotten out of hand and must be checked".

23 One further statement which is found  
24 in your report regarding promotion that we find  
25 disturbing is on page 115 and is attributed to a  
26 spokesman of the Wyeth Co.: "Generally it can be  
27 stated therefore, that informational and promo-  
28 tional expense is applied in relation to products  
29  
30





1 current or potential sales volume. The estimated  
2 distribution being 75% to the more important  
3 specialties and 25% to the balance of the product  
4 line".

5 This statement means to us that  
6 those products having the greatest current sales  
7 volume, that is new protected patented drugs, bear  
8 the major portion of promotional expense. Conse-  
9 quently the promotional expense on these protected  
10 drugs must be much higher than the average for the  
11 industry of 25% of the sales dollar as shown in  
12 Table XXIV of your report.

13 The proper solution to this problem  
14 would be a critical self-appraisal on the part of  
15 the manufacturer of this particular aspect of his  
16 operation. Again according to the information  
17 contained in your report, there are indications  
18 that some manufacturers are aware of this problem.  
19 However, it is felt that a closer study should be  
20 made by government as to what extent this dispro-  
21 portionate allocation of promotional expenses  
22 penalizes the public and what controls can be  
23 applied to arrive at a more equitable distribution  
24 of promotional expenses.  
25

26 It would appear from Table XXIV that  
27 monies spent by the pharmaceutical houses in Canada  
28 on research and quality control are not exorbitant  
29 nor do they account for a large percentage of the  
30



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1 cost. It is noted that only 5.43% of the net sales  
2 of 26 manufacturers is spent on research, quality  
3 control and grants and only 2.03% is actually spent  
4 on research. Further there are indications that  
5 much of the research done in Canada by manufacturers  
6 is really product development and patent research  
7 and that there is little spent on basic medical  
8 research. The relatively small proportion of medi-  
9 cal research done by manufacturers in Canada is  
10 illustrated by a comparison with that done in the  
11 United States. To quote page 140 of your report:  
12 "....a single firm in the United States spent six  
13 to eight times as much on research as did twenty-  
14 two Canadian firms which included the largest in  
15 the field. In summary the opinion of (research  
16 workers)....is that the amount of medical research  
17 performed in Canada is relatively limited".

19 The point about this fact is surely  
20 that the majority of Canadian manufacturers although  
21 they stress the value of research and its importance  
22 to progress in the medical field, and we agree with  
23 this point of view, apparently are actually doing  
24 little or none of it themselves. They instead  
25 appear to rely on the research of their parent  
26 companies in the United States and that work done  
27 in universities and hospitals. Therefore the large  
28 amounts of money spent by Canadian manufacturers  
29 in selling, promotions, and the protection afforded  
30



1       them by patents serves to give them market and price  
2       privileges when little of the basic research is  
3       done in Canada.

4               Other than the above observations on  
5       promotion and research costs, we can add little on  
6       the nature and conditions of drug manufacture in  
7       Canada. However, our review of the drug manufac-  
8       turing industry, which is based largely on the  
9       material collected by your research staff, indicates  
10      to us that regardless of possible collusion or  
11      price arrangements between manufacturers, the  
12      existing high costs of promotion should be investi-  
13      gated further. We would also agree with the state-  
14      ments made in your report that possibly the main  
15      reason for these high costs is the existing patent  
16      situation on drugs. To illustrate what these  
17      effects can be we would like to quote Chapter XVIII,  
18      Section 467 of that document:

19               "The information obtained in this  
20      inquiry appears to indicate that, at the manufac-  
21      turers' level, prices of certain drugs are affected  
22      by the control over the manufacture, distribution  
23      and sale of such drugs exercised through patents.  
24      The provisions of the Patent Act relating to compul-  
25      sory licenses appear to have proved ineffectual to  
26      combat this situation and the clear intent of the  
27      Act has been frustrated. This conclusion is not  
28      intended to imply any opinion about patents as such,  
29  
30



1 it is intended simply to indicate that, in relation  
2 to the sale of drugs in Canada, patents have been  
3 and are being used to create monopolistic situations  
4 which the Canadian law appears to have been designed  
5 to prevent. The control exercised over the manufac-  
6 ture, distribution and sale of certain drugs through  
7 patents has virtually eliminated price competition  
8 in respect of such drugs and has encouraged other  
9 forms of competition which, while possibly bringing  
10 other benefits to the public, have resulted in  
11 prices being increased rather than decreased. Prac-  
12 tices which are quite legal and unobjectionable in  
13 themselves (promotion, use of trade names, and the  
14 like) appear to have been carried to extremes  
15 because of the insulation of certain sectors of the  
16 industry from price competition by reason of the  
17 control exercised through patents".

18  
19 OBSERVATIONS

20 In addition to the areas of the drug  
21 industry previously covered, we would like to  
22 comment on the following aspects which we feel are  
23 important causes of the high cost of drugs in Canada  
24 and so should be examined closely by this Commission;  
25 generic versus trade name and patents.

26  
27 1. Generic versus Trade Name:

28 During the past few years there has  
29 been wide public controversy over the merit of  
30 prescribing and purchasing drugs by their Generic



1 versus Trade name, as one method of reducing the  
2 cost of prescriptions to the consumer. To cite a  
3 few examples of the differences of opinion concern-  
4 ing this controversy and the complexity of the  
5 matter we would like to quote from Page 220 of your  
6 study, "the so-called 'generic vs. trade name contro-  
7 versy is a misnomer; the real controversy is about  
8 the quality of the products of large established  
9 manufacturers as compared with those of small firms,  
10 an issue which is complicated by various sub-issues  
11 such as the importation and use of drugs from  
12 foreign sources".

14 We would also like to quote from the  
15 statement made by the Manitoba Pharmaceutical  
16 Association on the subject of generic name as it  
17 appears on page 68 of the Retail Structure of Drug  
18 Prices in Manitoba: "A recent study by the Pharma-  
19 ceutical Association of a representative group of  
20 500 prescriptions dispensed in Winnipeg revealed  
21 that approximately 8 percent were prescribed by  
22 generic name. Further investigation revealed that  
23 an additional 10 to 12 percent were of a suffi-  
24 ciently simple chemical formulae that they could  
25 have been prescribed and dispensed by generic name".

27 We believe that from the experience  
28 we have had with hospital and government institu-  
29 tional purchases of drugs that considerable cost  
30 savings can be realized through the use of generic





1 names. Because of the importance and the complex  
2 nature of this subject we feel that it requires a  
3 separate detail study.

4 2. Patents:

5 Although this subject was referred  
6 to earlier, we feel that it is important as it is  
7 possibly the major single reason for the present  
8 manufacturing promotion and price situation in the  
9 drug industry in Canada, and is also probably the  
10 key to effect changes in the industry for the  
11 future. This assumption seems to be borne by the  
12 statement made on page 259 of your report to quote:  
13 "Various reasons are advanced for the higher prices  
14 of new patent-controlled drugs and these have been  
15 discussed in the Statement. Regardless of what  
16 conclusions may be reached in respect of such  
17 matters, the fact which makes high prices possible  
18 is the patent control exercised over such drugs".

19 It is suggested that no investigation  
20 of the drug industry can be truly meaningful if it  
21 does not assess the effects of the Canadian patent  
22 laws and suggest possible revision.  
23  
24  
25  
26  
27  
28  
29  
30



/dpw

1 CONCLUSIONS

2 We hope that the information outlined  
3 above based upon our own investigations as well as  
4 our observations on the information compiled by the  
5 Investigation and Research Branch of the Combines  
6 Investigation Act will be of some assistance in  
7 your study.

8 We certainly do not consider that  
9 our review is in any manner exhaustive. Neverthe-  
10 less, on the basis of the facts and opinions  
11 presented in this brief we would like to draw the  
12 following conclusions:  
13

14 1. The present system of distributing  
15 drugs through the retail outlet does not appear to  
16 be the major reason for the high cost of drugs.  
17 However, as pointed out we feel that there can be  
18 some improvements made in the system of retail  
19 distribution.

20 2. The differences in the cost to  
21 the public of drugs dispensed through hospital  
22 pharmacies and retail outlets is, in our view,  
23 most revealing and should be investigated fully  
24 by this commission.

25 3. The evidence which your Director  
26 of Research has gathered indicates that promotion  
27 expenses on the part of manufacturers in Canada  
28 appear to be excessive and should be reviewed,  
29 particularly in relation to patents and the monies  
30



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1 spent on research and development.

2 4. In our view patents on drugs are  
3 possibly the major single reason for the present  
4 manufacturing, promotion and price situation in the  
5 drug industry in Canada and is also probably the  
6 key to effect changes in the industry in the  
7 future.

8 5. Because of the importance and  
9 complex nature of the question of prescribing  
10 drugs by generic versus trade name we feel that  
11 this subject requires a separate study.

12 Gentlemen, even if as a result of  
13 your present investigation you find no evidence  
14 of restrictive trade practices, price fixing, or  
15 collusion on the part of those engaged in any  
16 sector of the drug industry in Canada, we feel  
17 that there is still a need for an intensive inves-  
18 tigation of the entire pharmaceutical industry  
19 with constructive and practical recommendations  
20 to lower the present high cost of drugs.

21  
22 THE CHAIRMAN: Thank you, Mr. Mac-  
23 kenzie. Do you wish to make any comments yourself?

24 MR. MACKENZIE: No sir.

25 THE CHAIRMAN: There is one obser-  
26 vation I would like to make. In a large number  
27 of places throughout the brief you have referred  
28 to "our report". I would like to make it clear -  
29 this is partly in case the press should be  
30



1 referring to it, the document in question is this  
2 fairly large green book and I should state, so there  
3 will be no question about it, this is not a report  
4 under the Combines Investigation Act. It is a  
5 collection of material, mainly factual, which the  
6 Director of Investigation and Research has obtained  
7 largely by way of returns to questionnaires and, I  
8 think, correspondence and to some extent reference  
9 to authoritative publications.

10 It is merely intended to be the  
11 basis on which the Commission carries on and  
12 completes the inquiry. It is not in any sense a  
13 complete report and it does not purport to be such;  
14 so that there will be no misunderstanding about  
15 that.

16 The Commission may come to conclu-  
17 sions which could differ to quite an extent than  
18 those which the Director thought the facts pointed  
19 to. We may agree with him in many matters and  
20 disagree on others because of additional informa-  
21 tion we get.

22 I would like to make that point  
23 clear so that there will be no misunderstanding  
24 about it.

25 Nobody should think there is going  
26 to be two reports on this one inquiry, arising  
27 out of this one inquiry.

28 There was one further point I  
29  
30



1 thought at this time I would raise. No doubt you  
2 are familiar with this, Mr. Mackenzie and other  
3 officials from the Government; the fact that only  
4 a very small percentage of the sales dollar of  
5 manufacturers in Canada is represented by research  
6 expenditures of those companies does not mean that  
7 the public are not paying for research expenses,  
8 because, as you stated, a very large proportion of  
9 the drugs used in Canada are imported from the  
10 United States either in bulk or by dosage form and  
11 the companies in the United States do engage to  
12 quite a large extent in research.

13  
14 Certainly it is reasonable to  
15 suppose and I think it is a fact in the prices  
16 they charge their subsidiaries in Canada there is  
17 a relative expense item for research, which has  
18 been done in the United States.

19 We are not in a position to trace  
20 that at all completely or perhaps at all because  
21 these things are outside the jurisdiction of  
22 Canada. They are in the United States but the  
23 cost is in research insofar as the parent companies  
24 charge a proportion of that expense in the price  
25 they charge subsidiaries in this country; so that  
26 is something which bears upon the relative percen-  
27 tages of research expenses in Canada and in the  
28 United States.

29  
30 When you consider the relation to





1 their sales dollars of the two countries, there is  
2 a difference that is quite noticeable between the  
3 two countries because of that fact.

4 Mr. MacLeod, have you some questions  
5 you would like to ask at this time? I understand  
6 other officials who are here will answer specific  
7 points if they are raised.

8 MR. MACKENZIE: Yes.

9  
10 MR. MACLEOD: I think, Mr. Chairman,  
11 it would be useful if we have some further informa-  
12 tion on the pricing of these prescriptions dis-  
13 pensed through the hospitals under what is named  
14 as "Medicare". I wonder if there is anyone who  
15 can give any information on that? On what basis  
16 was the charge of \$1.25 arrived at? Why is the  
17 40¢ administrative charge used and so on?

18 MR. MACKENZIE: I think I can answer  
19 that.

20 Each recipient of social allowance  
21 in Manitoba is provided with what is commonly  
22 called a Medicare certificate, which they can take  
23 to the physician of their choice and if he pres-  
24 cribes drugs and they take the prescription to the  
25 hospital pharmacy in Greater Winnipeg - there are  
26 four hospital pharmacists where they can take  
27 these prescriptions to be filled - or to a retail  
28 pharmacist.

29 THE CHAIRMAN: That is only in  
30



1 Winnipeg?

2 MR. MACKENZIE: Yes. In Rural Mani-  
3 toba or outside of Winnipeg there are no hospital  
4 pharmacies to which they may take these. The  
5 figures given here are estimated per prescription  
6 in a retail pharmacy and simply totalling up the  
7 total cost of all the prescriptions issued or  
8 dispensed.

9 THE CHAIRMAN: Those are issued free?

10 MR. MACKENZIE: Yes.

11 THE CHAIRMAN: To the patient?

12 MR. MACKENZIE: No charge to the  
13 patient. The account comes to the Manitoba Govern-  
14 ment.

15  
16 THE CHAIRMAN: They are a direct cost  
17 to the hospital dispensary?

18 MR. MACKENZIE: That is right.

19 THE CHAIRMAN: Without any markup  
20 for profit?

21 MR. MACKENZIE: That is correct.

22 In the case of the retail trade, it  
23 is an agreement between the Manitoba Government  
24 and the Manitoba Pharmaceutical Association under  
25 which the retail pharmacist puts a price on the  
26 prescription, which is the suggested list - the  
27 manufacturers' list price less 15%, plus a dispen-  
28 sing fee, a suggested dispensing fee.

29 THE CHAIRMAN: So that the price  
30



1 which the Government pays to the retail drug does  
2 include some markup for profit. That is not true  
3 of the hospital dispensary?

4 MR. MACKENZIE: That is right.

5 The fee to the retail trade is stated  
6 in the report of the pharmacy as the manufacturer's  
7 suggested list price for the drug plus dispensing  
8 fee, less 15%.

9 MR. MACLEOD: So that if we take, for  
10 example, the \$2.82 per prescription, which is the  
11 first figure mentioned on page 3 ---

12 MR. MACKENZIE: Yes.

13 MR. MACLEOD: That \$2.82 would repre-  
14 sent 85% of what the purchaser outside of the  
15 plan would pay, that the ordinary customer would  
16 pay?

17 MR. MACKENZIE: Yes.

18 MR. MACLEOD: And in the City of  
19 Winnipeg the \$3.03 per prescription would be 15%  
20 less than the customer walking in off the street  
21 would pay?

22 MR. MACKENZIE: Correct.

23 MR. MACLEOD: And the \$4,009.92 is  
24 what; the total cost of the pharmaceutical  
25 products used in filling prescriptions?

26 MR. MACKENZIE: No. It is that cost  
27 plus the 40¢ per prescription charge which is a  
28 flat amount set after a cost study in the hospitals.  
29  
30



1 MR. MACLEOD: What is the procedure?  
2 Does the hospital pharmacist estimate the cost in  
3 the case of each prescription?

4 MR. MACKENZIE: Yes.

5 MR. MACLEOD: A person under the  
6 Medicare plan walks in and has a prescription filled.  
7 The hospital pharmacist puts a price on that, depen-  
8 ding on the medicinals used and adds 40%?

9 MR. MACKENZIE: Yes.

10 MR. MACLEOD: And that is submitted  
11 to the Government?

12 MR. MACKENZIE: That is right.

13 MR. MACLEOD: And the total of these  
14 in the period covered by your study, you have given  
15 as \$4,009 or \$1.65 each. Is that correct?

16 MR. MACKENZIE: That is correct.

17 MR. MACLEOD: I was interested in  
18 your statement about a saving of 7% on sales tax.  
19 I was wondering how that was calculated.

20 MR. PUBLOW: May I answer that ques-  
21 tion, please? I think we mentioned approximately.  
22 Our figures generally understand -- where a manu-  
23 facturer has to pay 11% on his product, and if it  
24 is sold to a hospital he doesn't get the full 11%  
25 back from Federal sources. It varies from company  
26 to company as to what the supplier will give the  
27 hospital. He won't give them the full 11%. In  
28 some instances it is around 7 and sometimes 6% but  
29  
30



1 this varies from supplier to supplier but the manufac-  
2 turer does not get his full 11% back from the Federal  
3 Government, as I understand it.

4 That is the reason we put "approximately"  
5 there. We didn't know just what the figure was.  
6 From my limited understanding on this it is approxi-  
7 mately 7% rather than 11.

8 THE CHAIRMAN: Are you Mr. Merrett?

9 MR. PUBLLOW: No, I am Mr. Publow.

10 MR. MACLEOD: There is some mention  
11 in the brief about calling for tenders in the case  
12 of certain drugs which could be ordered under generic  
13 names. In practice, what limitations did you find  
14 in ordering under generic names? Were there certain  
15 drugs you could not get under the generic name or  
16 anything like that?

17 MR. PUBLLOW: Actually this actually  
18 is just a report we got. We didn't actually go in  
19 and investigate every item which was purchased.  
20 These incidentally were for our mental hospital.  
21 We got a cross-section on where they were buying  
22 large bulk quantities. There may be many other  
23 medications that sent out for tenders but this is  
24 the only report we had on it.

25 MR. MACLEOD: It seems to be implicit  
26 in the brief that under certain instances it is  
27 not practical to call for tenders.

28 MR. PUBLLOW: Yes, the volume was  
29  
30





1 small, for one thing or there was possibly only one  
2 source of supply but this was just more or less a  
3 sampling that we got out. Some savings have been  
4 realized by tendering.

5 Incidentally this is just on the  
6 tender. This is not the percent that somebody in  
7 the retail might have to pay. There may be a  
8 difference in there.

9 MR. MACLEOD: Your 490%, which is  
10 the maximum referred to, was between the highest  
11 and lowest tender?

12 MR. PUBLOW: Yes.

13 MR. MACLEOD: It might conceivably  
14 be much higher if the percentage was made against  
15 what the retailer would have to pay?

16 MR. PUBLOW: That is true. We didn't  
17 want to make any assumption of that because we were  
18 not able to get the comparison for you.

19 MR. MACLEOD: It might conceivably  
20 also be much higher if it was compared with the  
21 regular price to the hospital?

22 MR. PUBLOW: This could be true. It  
23 would probably be interesting to look into that  
24 aspect.

25 MR. MACLEOD: But the information  
26 contained in the brief is based on information  
27 obtained from the purchasing agent and not from a  
28 first-hand study by yourself?  
29  
30



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1 MR. PUBLLOW: That is true.

2 THE CHAIRMAN: I would like to refer  
3 back to the 40¢ administrative charge again which  
4 the brief states does not cover the full overhead.  
5 Is that a deliberate undercharge or is it your  
6 experience has shown your cost per prescription is  
7 more than estimated?

8 MR. PUBLLOW: Well, actually we asked  
9 four hospitals to submit what they considered  
10 their drug costs, including the salary of the phar-  
11 macist and we did not ask them for the cost of  
12 such things as rent, light, heat and water which  
13 would be an indirect cost; so basically the 40¢  
14 cost is an average of the four hospitals, as to  
15 their direct cost. It is primarily salary to the  
16 individual.  
17  
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19 -  
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28 -  
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1  
2 THE CHAIRMAN: It will be the cost to  
3 them of the drug, plus the salary?

4 MR. PUBLOW: Yes, the \$1.25 would be  
5 -- the 40¢ is basically the salary of the individual  
6 putting up the drug.

7 THE CHAIRMAN: There is nothing for  
8 rent, or light or heat?

9 MR. PUBLOW: No, we thought it would  
10 be a little too difficult to come up with a figure  
11 on that.

12 THE CHAIRMAN: So the hospital pays  
13 a part of the cost, is that it?

14 MR. PUBLOW: Yes, this is true.

15 MR. MACLEOD: Are the costs of drugs  
16 administered to patients in hospital borne under  
17 the Government hospital plan?

18 MR. PUBLOW: Yes.

19 MR. MACLEOD: There is no charge to  
20 the patient at all?

21 MR. PUBLOW: That is true.

22 MR. MACLEOD: What is the rule about  
23 out-patients who just drop in for treatment?

24 MR. PUBLOW: I had better not make a  
25 statement on that, if you don't mind.

26 MR. MACLEOD: You are not sure?

27 MR. PUBLOW: I am not positive on  
28 that.  
29  
30



1 MR. MACKENZIE: It is my understanding  
2 that if the patient is a regular out-patient of the  
3 hospital that medications that he requires are  
4 provided under the plan.

5 MR. MACLEOD: Do you have any idea of  
6 either the total cost of drugs under the hospital  
7 plan to the Manitoba Government, or what percentage  
8 of the total cost of administering the plan would  
9 it constitute?

10 MR. PUBLOW: Together, drugs and  
11 surgical and medical supplies are approximately 8%.  
12 Drugs I would say roughly are 4%. But that is a  
13 rough estimate.

14 MR. MACLEOD: Would you be in a posi-  
15 tion to say whether the prices of certain drugs  
16 have come down within recent months, in the last  
17 six months?

18 MR. PUBLOW: I wouldn't want to  
19 reply as a statement of fact, but it is my impres-  
20 sion that there has been some reduction, but I  
21 wouldn't want that as a statement of fact.

22 THE CHAIRMAN: Is it also your  
23 impression that the prices of some drugs have  
24 gone up in that period?

25 MR. PUBLOW: Actually my impression  
26 over the past year is that prices of individual  
27 drugs have not gone up, but possibly new ones  
28 coming on are higher priced, but when a drug is  
29  
30



1 first marketed it is not my impression that prices  
2 have gone up over the years, but rather, if any-  
3 thing, gone down.

4 THE CHAIRMAN: Are you speaking now  
5 of ethical drugs?

6 MR. PUBLLOW: Yes sir.

7 MR. MACLEOD: Does the Commission  
8 exercise any control over the drugs used, or is  
9 that a matter entirely to the physicians?

10 MR. PUBLLOW: Within hospitals do you  
11 mean?

12 MR. MACLEOD: The drugs which the  
13 Commission will pay for?

14 MR. PUBLLOW: We cover all medica-  
15 tions in the hospital.

16 MR. MACLEOD: And the medications  
17 prescribed are entirely up to the doctors?

18 MR. PUBLLOW: That is true.

19 MR. MACLEOD: And you don't put  
20 restrictions or reservations on them in any way?

21 MR. PUBLLOW: There is in the form of  
22 a budget which we submit, some sort of control,  
23 yes, but not in the nature of the individual drug  
24 prescribed.

25 MR. MACLEOD: It is an attempt to  
26 keep the overall cost as low as you can?

27 THE CHAIRMAN: Does any member of  
28 the delegation wish to make any further comment?  
29  
30





1 MR. GREGORY: May I ask the delegation  
2 for one word of clarification? This is not examina-  
3 tion. The footnote at the bottom of page 3. We  
4 should appreciate confirmation that it is intended  
5 to convey there in the last phrases, pharmacists in  
6 both areas use the same prescription pricing schedule  
7 in dealing with Medicare accounts. Is that what it  
8 is intended to convey?

9 MR. MACKENZIE: Yes, it is intended to  
10 convey that.

11 THE CHAIRMAN: Thank you very much,  
12 gentlemen. We appreciate your coming. You have  
13 given us some matters to which we will have to devote  
14 some attention.

15 MR. MACKENZIE: Thank you.

16 MR. MACLEOD: The tentative arrange-  
17 ments were that a brief would be read this afternoon  
18 on behalf of the pharmacists, and at 10 o'clock  
19 tomorrow morning certain pharmacists were to appear.

20 THE CHAIRMAN: Mr. Gregory, are you  
21 appearing for the pharmacists' association?

22 MR. GREGORY: Yes Mr. Chairman. If I  
23 may add to your counsel's remarks, the members of  
24 the Association will be available tomorrow morning,  
25 and will be prepared to answer any questions you  
26 may have relating to the brief or to the general  
27 field of matters which has been brought out today.

28 Before I commence to read my  
29  
30



1 Association's brief, Mr. Chairman, perhaps I should  
2 indicate the limitations which the Association has  
3 placed on itself. We are aware that submissions  
4 will be made to your Commission by the Canadian  
5 Pharmaceutical Association. At those sittings we  
6 are informed that the Canadian Pharmaceutical Asso-  
7 ciation will deal with the general situation of the  
8 retail pharmacist in Canada, and will deal with  
9 most of the material contained in the statement of  
10 the Director of Investigation and Research, where  
11 it relates to matters in the field of interest of  
12 the retail pharmacist, and the members of the  
13 various provincial pharmaceutical associations.  
14 In this brief we are limiting ourselves to Manitoba  
15 matters, and trying to stay away from national  
16 matters wherever possible although in some cases it  
17 is not possible to do this.

18  
19 THE CHAIRMAN: We also had a brief  
20 from the Maritimes Association.

21 MR. GREGORY: Yes, I was aware of  
22 that. We had an opportunity of seeing it here in  
23 Winnipeg.

24 Mr. Chairman and Honourable members  
25 of the Commission.

26 The Manitoba Pharmaceutical Associa-  
27 tion, being the governing body of the profession  
28 of pharmacy in the Province of Manitoba is appearing  
29 before the Commission voluntarily at the Winnipeg  
30



1       Sittings as the Association has facts and informa-  
2       tion to present to the Commission which may assist  
3       the Commission in the performance of the Inquiry.  
4       The Association is also of the view that it has a  
5       duty to the community to come forward with whatever  
6       facts may be in the possession of its members which  
7       may assist the Commission.

8               The scope of the Inquiry and its terms  
9       of reference are quite broad but, insofar as the  
10      Province of Manitoba is concerned, there is no  
11      manufacturing of drugs of any consequence. This  
12      brief therefore, for the large part, will deal with  
13      the charges made to patients in retail pharmacies  
14      for prescription items.

15              It should be noted at the outset that  
16      the Manitoba Pharmaceutical Association, which was  
17      first incorporated by the legislature of this  
18      province in 1878, is a body constituted for the  
19      regulation of the profession and is very similar to  
20      statutory created governing bodies for other pro-  
21      fessions in this and other provinces. "The Pharma-  
22      ceutical Act" creates the governing body and  
23      provides for the day to day operations of the gover-  
24      ning body and for the government of the profession  
25      and, generally speaking, also prescribes the condi-  
26      tions which must be met to become qualified to  
27      practice as a pharmacist and deals with matters  
28      concerning the operation of retail pharmacies and  
29  
30



1 the ethical conduct of members of the profession and  
2 so forth. However, this act is different from other  
3 statutes incorporating professional bodies in other  
4 fields in that it also regulates the sale, the  
5 handling and the dispensing of certain pharmaceutical  
6 products in relation to those matters that are within  
7 the legislative jurisdiction of our legislature.  
8 Enforcement of this latter form of regulation is in  
9 the hands of the inspection staff of the Manitoba  
10 Pharmaceutical Association.

11 Review of the Act as a whole demon-  
12 strates that the legislature has reposed a conside-  
13 rable trust in the association in matters relating  
14 to a most important field of activities in the  
15 matter of the health and well being of the community.  
16 A copy of the Pharmaceutical Act and its amendments  
17 is annexed to this submission and is marked as Annex  
18 No. 1.

19 I am afraid that I must apologise in  
20 that what you are receiving is not a consolidation  
21 of the statute. The legislature passed certain  
22 amendments in 1961, and it was not possible in the  
23 time available to prepare a consolidation for your  
24 purposes. The amendments are the routine house-  
25 keeping changes that occur in this type of legis-  
26 lation.

27 THE CHAIRMAN: This is entitled Bill  
28 78?  
29  
30



1 MR. GREGORY: Yes.

2 THE CHAIRMAN: It does not contain  
3 all that would be in the Pharmaceutical Act, but  
4 only the amendments made this year?

5 MR. GREGORY: Yes, and the 1955  
6 consolidation with the amendments brings the Act  
7 up to date.

8 The Act provides that the Association  
9 has the power to create and enforce a code of  
10 ethics and the association does have such a code  
11 of ethics. Annex No. 2 to this submission is a copy  
12 of the present code of ethics. It will be observed  
13 that the Act does not purport to give the Associa-  
14 tion any power to deal in the matter of retail drug  
15 prices and in fact it is the Association's view that  
16 any attempt by any group to control the charges made  
17 to patients in retail dispensaries is highly improper.  
18 It will be observed that the code of ethics concerns  
19 itself only with price advertising and the only  
20 possible breach of the code of ethics in relation to  
21 price would be if a member breached the advertising  
22 ethic. That is to say, unethical advertising  
23 includes certain forms of price advertising.  
24

25 This is treated by the Association in  
26 the same light as the man who has a sign in his  
27 dispensary saying prescriptions accurately compounded.  
28 This is considered unethical and in the view of the  
29 Association it implies that the man down the street  
30





1 does not accurately compound prescriptions.

2 THE CHAIRMAN: Would you give me an  
3 example of the kind of price advertising that is  
4 looked on as unethical?

5 MR. GREGORY: Perhaps the gentlemen  
6 with me can make a note, and someone who knows of  
7 an example can recite it tomorrow morning.

8 THE CHAIRMAN: Unethical price adver-  
9 tising can mean one thing to one person and a  
10 different thing to another person.

11 MR. GREGORY: My recollection may not  
12 be accurate now for the purposes of the record, so  
13 I would like to answer that question tomorrow  
14 morning.

15 THE CHAIRMAN: All right then.

16 MR. GREGORY: In any event, the  
17 Association considers price fixing as unprofessional  
18 and not consistent with the tradition of public  
19 service in the pharmaceutical profession.

20 However, because the majority of the  
21 members of the Association are engaged in retail  
22 pharmacy the Association does have some interest  
23 in matters concerning price procedures and methods  
24 and does have information from its members and  
25 other sources to bring before this Commission.

26 In the next bit of this submission  
27 you will find I may be repeating some information  
28 contained in the brief of the provincial officials.  
29  
30



1 If you will bear with me, both briefs were written  
2 independently.

3 In the Province of Manitoba the provin-  
4 cial government administers what is commonly referred  
5 to as, the "Medicare Plan", which is a plan whereby  
6 residents of this province in certain categories who  
7 receive welfare assistance may go to the medical  
8 practitioner of their choice for medical services at  
9 the expense of the Province, and arrangements have  
10 been entered into with the medical profession,  
11 dental profession, and so forth, whereby accounts  
12 for professional services are rendered to the Province  
13 on a special basis.  
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FF/BL/dpw

1 It should be noted that the services  
2 rendered by the medical and dental practitioner  
3 would involve, in the great majority of cases, only  
4 time charges. As is usual, the medical treatment  
5 often involves the use of drugs and medicines  
6 dispensed by the retail pharmacists who fill the  
7 prescriptions and whose accounts in these cases,  
8 are paid by the Province. As a direct result,  
9 provincial authorities became very interested in  
10 charges made to patients in retail pharmacies. At  
11 the request of the provincial officials concerned,  
12 members of the association submitted a uniform  
13 system of dispensing charges to be used in the case  
14 of Medicare prescriptions, where accounts are to be  
15 submitted to the province for payment.  
16

17 There were discussions between Govern-  
18 ment officials and officers of the Association, and  
19 at about this time last year, that is in 1960, the  
20 then Minister of Health and Public Welfare, and  
21 officers of the Association, agreed that it would  
22 be useful to have a review of charges made in  
23 retail pharmacies in Manitoba for the dispensing of  
24 drugs and medicines. All parties agreed that such  
25 a study could best be accomplished by means of a  
26 Joint Committee comprising officials of the Provin-  
27 cial Government and representatives of the Pharma-  
28 ceutical Association and of the retail pharmacists.  
29 In due course a Joint Committee was created  
30



1 comprising Mr. Holland, Mr. Richardson and Mr.  
2 Anderson, who are, respectively, president, vice-  
3 president, and registrar of the Manitoba Pharmaceu-  
4 tical Association; Mr. Barlow, a councillor of the  
5 Manitoba Pharmaceutical Association; Mr. Moir,  
6 president of The Manitoba Retail Druggists Associa-  
7 tion representing the retail pharmacists; Messrs.  
8 Merrett and Ireland and Miss Cwihun, representatives  
9 of the Provincial Department of Industry and Commerce.  
10 In addition, Mr. Publow, of the Provincial Depart-  
11 ment of Health and Public Welfare, was appointed to  
12 the Committee as an advisor. Messrs. Merrett and  
13 Holland were appointed co-chairmen of the Committee.  
14 This Joint Committee gave careful study to the  
15 matter of charges made to patients in retail phar-  
16 macies in this province and completed their report  
17 in May of 1961, and this report has recently been  
18 published. The Report of the Joint Committee is  
19 annexed to this submission and is numbered as Annex  
20 No. 3. The Association and its membership are  
21 anxious to bring this Report before the Commission  
22 as the circumstances surrounding its preparation  
23 and the study behind the preparation make it  
24 different and perhaps more useful than some of the  
25 evidence which will be presented to the Commission  
26 in the course of this Inquiry. A great majority  
27 of the submissions will be prepared by or on behalf  
28 of interested persons or groups and will advocate  
29  
30



1 the views held by the particular person or group.  
2 In the case of the Report of the Joint Committee  
3 the study and report reflects the views and findings  
4 of civil servants of the Province of Manitoba, whose  
5 independence of thought can hardly be questioned  
6 and, the Report was unanimous.

7 The terms of reference of the Committee  
8 were as follows:

9 "The Government has a primary respon-  
10 sibility to remain at all times sensitive to patterns  
11 of public thinking and to encourage or sponsor the  
12 production of sound information which may be neces-  
13 sary to dispel the development of misunderstanding.  
14 At present, when the Government will be spending  
15 public money to provide drugs to social assistance  
16 cases under the new Medicare program, in light of  
17 the evident public concern, it is important to  
18 study the retail drug price situation. This study  
19 will investigate whether or not retail pharmacists  
20 in Manitoba are receiving a reasonable return for  
21 services performed".

22 The Committee found as a fact that  
23 retail pharmacists are not receiving an unreasonable  
24 return for the services they perform.

25 Before dealing with the highlights  
26 of this Report it should be mentioned that both,  
27 in the Report of the Joint Committee and in the  
28 Statement of the Director of Investigation and  
29  
30





1 Research, comparisons were made on a province by  
2 province basis on average charges made for prescrip-  
3 tions which were valid at the time the tables were  
4 prepared in both the Report and in the Statement.  
5 These tables indicated that the average charges  
6 made for prescriptions in Saskatchewan were the  
7 lowest in Canada. Recently there have been changes  
8 made in the Province of Saskatchewan which have  
9 caused an increase in the average charges made for  
10 prescriptions, with the result that at present,  
11 charges made in Manitoba are the lowest in Canada.  
12 No doubt, the representations made from the groups  
13 in Saskatchewan will present information regarding  
14 these changes.  
15

16 To put it briefly, the study found  
17 that charges made by retail pharmacists to patients  
18 were not regulated in any way by persons acting in  
19 concert, and, in fact, did find a lack of uniformity  
20 in the charges made, notwithstanding that there is  
21 in existence a dispensing fee schedule, which will  
22 be dealt with later in this submission.

23 I may say for the purpose of clarifi-  
24 cation that this paragraph deals with the general  
25 public and retail pharmacists, not the Medicare  
26 patient.

27 The charge made to the patient takes  
28 into account the fact that the retail pharmacist is  
29 a professional man who dispenses drugs and medicines  
30



1 in accordance with the instructions of a medical  
2 practitioner and, this is quite different from the  
3 simple matter of pricing "trade goods".

4 The retail pharmacist in Manitoba,  
5 unlike hospitals and institutions and governmental  
6 bodies, is in no bargaining position on his  
7 purchases of drugs and pharmaceuticals. In order  
8 to obtain supplies he must pay the price set by  
9 the supplier. The only variation in prices charged  
10 him comes as the result of the volume of a particu-  
11 lar purchase. Unlike trade goods, maintaining a  
12 stock of drugs is quite expensive. The vendor of  
13 trade goods may eliminate slow moving items, or  
14 obsolete items by conducting a sale or by disposing  
15 of his merchandise to a surplus outlet. In the  
16 case of items which one may only obtain from a  
17 retail pharmacist an obsolete item can only be  
18 destroyed by the pharmacist at his own expense.  
19 A further expense which the pharmacist encounters  
20 and which is not encountered by other retail busi-  
21 ness is the fact that he makes his purchases in  
22 units of 50, 100, 500 and 1,000, multiples thereof.  
23 Prescriptions on the other hand are written to suit  
24 the case and various odd lots are prescribed leaving  
25 the pharmacist with a broken number of a particular  
26 item which may or may not fit the number required  
27 by the next prescription, if any, for this item.  
28 Another element which adds to cost is the fact that  
29  
30



1 the retail pharmacist must maintain a stock of drugs  
2 in anticipation of prescriptions which may or may  
3 not come to him and, too often, the prescriptions  
4 do not come in sufficient number, or at all, and the  
5 stock must be destroyed at the end of its shelf life.  
6 Prescription drugs are not trade goods and cannot be  
7 sold or merchandised by the pharmacist but may only  
8 be employed in filling or compounding prescriptions  
9 written by a medical practitioner. Therefore, it is  
10 submitted that the pharmacist is subjected to a  
11 considerable higher cost of maintaining stock than  
12 any other retail type of operation.

14 The law of this province requires that  
15 a licenced or registered pharmacist be in charge of  
16 a retail pharmacy during the hours it is open for  
17 business. The registered or licenced pharmacist is  
18 a person with a minimum of a four year University  
19 course and his level of remuneration should therefore  
20 be higher than in other retail operations where a  
21 person professionally trained is not required. It  
22 is difficult therefore, to relate this cost to the  
23 case of an ordinary retail business. In addition,  
24 in areas like the Metropolitan Winnipeg area, the  
25 majority of retail pharmacists service surrounding  
26 residential neighborhoods and in order to serve the  
27 community they must remain open for 12 or more hours  
28 in a day for 6 or 7 days in a week. As the law  
29 requires that the premises be in the charge of a  
30



1 registered pharmacist, at all times, where there is  
2 a one man operation the proprietor is the pharmacist  
3 and he is therefore a person engaged in his business  
4 for a very large number of hours per week. If he is  
5 to work shorter hours he must employ a registered  
6 pharmacist and he is subjected to a relatively high  
7 salary cost in terms of other retail operations.  
8 It must be apparent that not only does carrying on  
9 the operation of a retail pharmacy require a profes-  
10 sionally qualified person, but such a person must  
11 have managerial training and abilities as well.  
12 Therefore, when the tables in the report are  
13 reviewed, although comparisons are made with other  
14 retail operations, it should be noted that such  
15 comparisons are not valid unless the particular  
16 nature of the costs of the operations of a retail  
17 pharmacist are borne in mind.

18  
19 As was stated in the Statement of  
20 the Director, there are classes of drugs dispensed  
21 in retail pharmacies but one will observe that the  
22 "mark up" of "discount" regardless of the class is  
23 uniform. It has been the experience of the retail  
24 pharmacists in Manitoba that the discount allowed  
25 on the drug item which may be sold without a pres-  
26 cription, but which may only be sold in a retail  
27 pharmacy, is sufficient to meet the costs of sales  
28 and some profit, if the sale is made by a sales  
29 clerk who is not a pharmacist. Then there are  
30



1 items which must be entered in the "poison book"  
2 and which do not require a prescription but which  
3 must be sold by the pharmacist. This extra work,  
4 of course, increases the cost of sales. In the  
5 case of a routine transaction where the patient  
6 appears with a written prescription a very great  
7 and serious responsibility is assumed by the pharma-  
8 cist involving his professional skill and knowledge.  
9 In such a case, the cost of sales is increased even  
10 if only to the extent of the responsibility assumed  
11 by the pharmacist in dispensing the item in the  
12 manufacturer's container but under his label, as no  
13 one will disagree that he assumes a great responsi-  
14 bility the moment he affixes his label.

15  
16 The Statement of the Director and  
17 the Report of the Committee go into some detail in  
18 the extra work involved where the pharmacist  
19 dispenses what are referred to as "oral narcotics"  
20 and "non-oral narcotics". These items are subject  
21 to strict control under the Provincial and Federal  
22 laws and records must be kept in the manner pres-  
23 cribed by law, and verifications must be made in  
24 the manner prescribed by law, and all of these  
25 acts must be done by the pharmacist. The pharmacist  
26 is, of course, subject to inspection and audit by  
27 the inspectors enforcing the Provincial law and  
28 Federal law regarding these items.

29 The next paragraph deals with the  
30





1 attitude of the lay patient.

2 It is readily apparent, however, that  
3 to a lay patient, it may appear that the retail  
4 pharmacist is just only another sort of retailer  
5 dealing with a special class of goods. We submit  
6 that this is not so, as the pharmacist is perfor-  
7 ming a professional service and is assuming the  
8 greatest of responsibilities regarding the patient's  
9 health and in addition, by following procedures  
10 laid down by law, is an instrument of control in  
11 the handling of narcotics and dangerous substances.  
12 His dispensary does not deal in trade goods, but  
13 must at considerable expense, maintain on its  
14 shelves a very wide variety of drugs and compounds  
15 in order to serve the community.

17 All of the foregoing is to indicate  
18 to this honourable Commission that, while compari-  
19 sons have been made with other retail businesses in  
20 the Report of the Joint Committee and in the State-  
21 ment of the Director, this Association submits that  
22 this is a case where these are only the best compa-  
23 risons that may be made and the peculiar nature of  
24 the retail pharmacist's operation is so different  
25 that the tables cannot be interpreted at face value,  
26 and that consideration of the tables must allow for  
27 the special situation of the pharmacist in terms of  
28 cost of operating his dispensary.

29 The comparisons between pharmacist's  
30



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1 operations in the province of Manitoba and in other  
2 provinces as well as comparisons of other retail  
3 businesses in Manitoba and in the other provinces  
4 become more meaningful if the essential differences  
5 in the cost of conducting a prescription dispensary  
6 are kept in mind.

7           The Report of the Joint Committee  
8 also deals with the level of remuneration of pharma-  
9 cists and of other professions and in particular it  
10 deals with the salaries of employed pharmacists and  
11 the salaries of employed professionals in other  
12 fields and, as well, deals with self employed phar-  
13 macists, pharmacists in partnership and pharmacists  
14 who are the principals of incorporated pharmacies  
15 in comparison, where figures are available, with self  
16 employed professionals and professionals in partner-  
17 ship in other fields. It is observed that while  
18 1960 figures were available for members of the  
19 pharmaceutical profession, for the large part, 1958  
20 figures only were available for other professions,  
21 and the study makes note of this and takes this  
22 into account.

23           The study also relates sales of  
24 retail pharmacies as a percentage of total retail  
25 sales in this province and other provinces, per  
26 capita sales in this province and other provinces  
27 and the text and tabular matter in this connection  
28 is self explanatory. Likewise with the average  
29  
30



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1 costs of prescriptions and other statistical data  
2 in this connection.

3 The Director of Investigation and  
4 Research in his Statement dealt with the matter of  
5 price schedules used in the various provinces and  
6 this subject is also developed in the Report of the  
7 Joint Committee. A copy of the current Dispensing  
8 Fee Guide now used in Manitoba is annex four to  
9 this submission and in the text of the Report of  
10 the Joint Committee is an explanation of how this  
11 guide is used.

12 Although this memorandum is used by  
13 many members of the Association, its use is not  
14 universal and its use is not compulsory. The Guide  
15 was developed as a means of demonstrating to retail  
16 pharmacists and informing retail pharmacists of one  
17 method of computing charges to be made to patients  
18 in retail pharmacies, which is compiled from a  
19 proper costing view. The economics of retail phar-  
20 macies, particularly in the case of the smaller  
21 pharmacies, are quite complex and yet the retail  
22 pharmacist and his business cannot bear the heavy  
23 expense of sophisticated accounting and cost  
24 accounting investigations into costs. Members of  
25 the Association in the past had found that smaller  
26 operations very frequently were losing money in  
27 the absence of any information to assist the phar-  
28 macist in computing his charges. The Association  
29  
30



1 distributes this memorandum as part of its education  
2 and information service to its members and it is  
3 emphasized that use of this method is entirely volun-  
4 tary and that many members of the Association use  
5 variations and other methods of computing their  
6 charges. I should add here that the special Medi-  
7 care is based on the dispensing fee guide; and I  
8 should also add that the Association does dissemi-  
9 nate information which it considers to be of value  
10 to its members in matters such as these. An  
11 example would be in recent years members in many  
12 cases advised that they should examine their soda  
13 fountain operation, as some members have found  
14 by eliminating their soda fountain operation they  
15 were losing considerably less money at this side  
16 of the store. The Association makes this informa-  
17 tion available as a matter of course.

18 Again it should be observed when  
19 considering the schedule method of arriving at  
20 charges that the retail pharmacist is not in a  
21 position to bargain for the price which he pays  
22 for drugs and pharmaceuticals.  
23  
24  
25  
26  
27  
28  
29  
30



/JC/dpw

1 As a final reference to the Report  
2 of the Joint Committee, it is noted that this  
3 Report uses the "mark up" expression when dealing  
4 with the prices paid by retail pharmacists for  
5 drugs, while the Statement of the Director uses  
6 the expression "discount" when dealing with prices  
7 paid by pharmacists. When the committee was  
8 making its study the officials of the Department  
9 of Industry and Commerce suggested that "mark up"  
10 be used in making the comparative study so that  
11 figures from other retail business would be more  
12 readily comparable.  
13

14 As you are aware, gentlemen, you  
15 often get the situation where one man is talking  
16 about three-quarters and the other man is talking  
17 about four-fifths and they are talking about the  
18 same thing in terms of discount and mark up.

19 The Association and its members  
20 express their appreciation to this honourable  
21 Commission for allowing this presentation to be  
22 made at this City.

23 All of which is respectfully submit-  
24 ted.

25 THE CHAIRMAN: Do you wish to make  
26 any comments yourself at this time, Mr. Gregory,  
27 to add to what you have just said by reading the  
28 brief?  
29

30 MR. GREGORY: I don't believe so,





1 Mr. Chairman, thank you.

2 THE CHAIRMAN: There are some members  
3 of the Association who will be here tomorrow morning  
4 to answer questions or to make any further statements  
5 which they may wish to make?

6 MR. GREGORY: Yes, Mr. Chairman. We  
7 have endeavoured to gather a group who should be  
8 able to field any question you may have.

9 THE CHAIRMAN: Mr. MacLeod, have you  
10 anything further?

11 MR. MACLEOD: No sir.

12 THE CHAIRMAN: Thank you, Mr. Gregory.  
13 We will adjourn until tomorrow morning.

14 MR. GREGORY: At 10 o'clock, Mr.  
15 Chairman?

16 THE CHAIRMAN: Yes, at 10 o'clock.  
17 Is there anything further this afternoon, Mr. Mac-  
18 Leod?

19 MR. MACLEOD: Nothing, sir.

20 THE CHAIRMAN: We will adjourn until  
21 10 o'clock tomorrow morning.

22 --- Whereupon the proceedings adjourned at 3.35  
23 p.m. until 10 a.m., July 18th, 1961.  
24  
25  
26  
27  
28  
29  
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Winnipeg, Manitoba, 626  
Tuesday, July 18th,  
1961.

G/dpw

1 --- On resuming at 10.10 a.m.

2  
3 THE CHAIRMAN: The hearing will resume.  
4 Mr. MacLeod, have you any programme for this morning?

5 MR. MACLEOD: I understand that Mr.  
6 Gregory has several witnesses from the Pharmaceutical  
7 Association. What procedure did you propose, Mr.  
8 Gregory?  
9

10 MR. GREGORY: Mr. Chairman, at least  
11 one or two of the gentlemen have some comments and  
12 observations to make on the provincial brief that  
13 was submitted yesterday, and the other gentlemen are  
14 available to deal with any questions which the  
15 Commission or your counsel may have, and we are pre-  
16 pared to make, of course, the answer to the question  
17 which arose while I was making my written submission  
18 yesterday.  
19

20 THE CHAIRMAN: To begin with, perhaps  
21 we had better have the names of those appearing, and  
22 if they have offices in the Association?

23 MR. GREGORY: On my right is Mr. J.F.  
24 Holland, President of the Association; Dr. J.R.  
25 Murray, Director of the School of Pharmacy of the  
26 University of Manitoba; Mr. J.W. Richardson, Vice-  
27 President of the Association; Mr. M.A. Anderson,  
28 who is the Registrar of the Association.

29 Mr. Holland and Mr. Richardson are  
30 practising retail pharmacists.



1 THE CHAIRMAN: And you said two of  
2 these gentlemen will be making some comments on the  
3 provincial brief?

4 MR. GREGORY: Yes, I believe Mr.  
5 Richardson has some views to express. I don't know  
6 about the other gentlemen. No, I think it is just  
7 Mr. Richardson.

8 THE CHAIRMAN: Would you care to make  
9 your comment then. If you are going to make any  
10 statements of fact, perhaps you had better go  
11 through the procedure and be sworn. We had to do  
12 that in the eastern places, and I think we had  
13 better just continue with this, just so that there  
14 won't be any question arise on that score.  
15

16  
17 J.W. RICHARDSON, sworn

18 MR. RICHARDSON: Mr. Chairman, the two  
19 comments on the Provincial Government's brief yester-  
20 day. One was on page 4 of their brief, on the  
21 second paragraph, about the fifth line from the  
22 bottom of the page. This could be a typographical  
23 error. I don't think Mr. Mackenzie meant it just  
24 the way it is written. To summarize this report,  
25 it is found that although the remuneration which  
26 pharmacists realise is generally greater than that  
27 received by owners and proprietors of any other  
28 types of retail outlets. Our combination brief  
29 with the Government, that is the pharmaceutical and  
30



1 Provincial Government brief, read many other, not any  
2 other.

3  
4 On page 2 of our brief, that is the  
5 Joint Committee of the Pharmaceutical Association.

6 "While it is agreed that the remuneration which pharma-  
7 cists realise is generally greater than that received  
8 by owners and proprietors of many other retail out-  
9 lets, it is felt that it is not unfair or unreasonable  
10 in view of the professional training of the pharma-  
11 cist and the services he makes available to the  
12 community". Many other forms of retail establish-  
13 ments is the way it is written in our brief. That  
14 is the joint brief, we stated many. Mr. Mackenzie's  
15 brief said any. I think that is just a slip on  
16 their part, because there are examples where we are  
17 not --

18 THE CHAIRMAN: You take in a lot of  
19 territory when you say any.

20 MR. RICHARDSON: Yes, I just wanted  
21 to draw that to your attention, sir.

22 The second thought I have on Mr.  
23 Mackenzie's brief yesterday, on page 3, where he is  
24 quoting prices of Medicare prescriptions, and just  
25 a comment on that, sir. He has given an average  
26 prescription price in rural Manitoba of \$2.82, and  
27 in the City of Greater Winnipeg, \$3.03. These were  
28 prices submitted by pharmacists to the Government,  
29 less 15%. These prices seem high in comparison to  
30



1 the average prescription price as dispensed to the  
2 customer in the store who is not a Medicare patient.  
3 Now, I don't remember Mr. Mackenzie explaining this  
4 yesterday.  
5

6 The Provincial Government has suggested  
7 that where feasible, and possible, that the physician  
8 write a prescription, prescribe for a month's quan-  
9 tity of a medication, if it is thought that the  
10 patient is to require a month's supply of that medi-  
11 cation, with the result that we are receiving larger  
12 prescriptions, that is prescriptions for larger  
13 quantities than the physician would normally write  
14 for a non-Medicare patient. A non-Medicare patient  
15 may not have the cash, or may not be willing to take  
16 a month's supply of some medication. They are  
17 satisfied with a week or two weeks' supply. Now,  
18 the Government is trying to eliminate a certain  
19 amount of expense by asking the physicians, where  
20 possible, to prescribe a larger quantity, and this  
21 in my thought is one reason for this apparent higher  
22 price on Medicare prescriptions than on the normal  
23 prescription the consumer would buy.  
24

25 THE CHAIRMAN: The average quantity  
26 of the Medicare prescription being larger, the price  
27 per prescription will be higher, though the cost  
28 for doses may even be lower?

29 MR. RICHARDSON: That is right, sir.  
30 On our method for pricing, if we dispense two lots





1 of 50, the price for the two lots would be higher  
2 than the price for one lot of a 100, so this has  
3 given the impression of a higher unit price per  
4 prescription, higher than the consumer would normally  
5 buy.  
6

7 THE CHAIRMAN: I have run across else-  
8 where the idea that manufacturers, in putting up  
9 dosage forms of drugs, particularly tablets and  
10 capsules, tend to put them in containers that will  
11 take 10, 5, 50 or a 100, and some forms of medication  
12 the patient may only need 5 or 6 or 8 or 10, but has  
13 to buy 12.

14 MR. RICHARDSON: There are very few  
15 instances where we will dispense a larger quantity  
16 than what the doctor would prescribe.

17 THE CHAIRMAN: Oh, quite.

18 MR. RICHARDSON: If the original  
19 container contained 16 capsules of tetracycline for  
20 instance, this is considered a four-dose treatment  
21 for most conditions, four a day, and the manufacturers  
22 have put it up in that size for convenience. The  
23 physician may only want a two-day treatment, and  
24 prescribe 6 or 12, and we will dispense that quan-  
25 tity only.  
26

27 THE CHAIRMAN: You dispense what the  
28 prescription prescribes?

29 MR. RICHARDSON: Yes.

30 THE CHAIRMAN: I am wondering whether



1 the amount that the manufacturer puts in his package  
2 has been found in your experience to be sometimes  
3 larger than is necessary, to an extent that might  
4 warrant making a smaller package?

5  
6 MR. RICHARDSON: I cannot answer for  
7 the manufacturer, sir, but just in personal  
8 experience it would seem that they are trying to,  
9 now I am again, I want to emphasize that this is a  
10 personal thought, they are trying to tell the doctor  
11 that 16 capsules is a dose when they put it up in  
12 30 per vial. That may be so in a lot of instances,  
13 but the doctor may feel that 12 is sufficient, and  
14 he prescribes that, and it is dispensed.

15 THE CHAIRMAN: I was talking to one  
16 manufacturer recently, and he said that they had  
17 been developing a combination and a method of pro-  
18 ducing a particular, I call it a pill or tablet,  
19 the effect or operation of which was spread over a  
20 much longer period of time than had been the  
21 experience with that type of drug in earlier forms,  
22 and therefore instead of taking one every four  
23 hours it is now only one every eight or twelve  
24 hours, and only eight instead of sixteen, and  
25 consequently this manufacturer was proposing to  
26 put up a dosage quantity of eight or ten, and I  
27 wondered if that kind of experience meant anything  
28 in the respect of cost to the patient. If there  
29 is anything to look at in that regard perhaps to  
30



1 save the patient buying more than he needs?

2 MR. RICHARDSON: Not necessarily so.  
3 There are quite a lot of these which we call a long-  
4 acting product, and instead of acting for four hours  
5 they will act for eight or twelve, but whether there  
6 is actually a saving to the patient -- I mean they  
7 are going to get less tablets but the individual  
8 longer acting tablet will cost more, not necessarily  
9 double, than the short-acting tablet.  
10

11 THE CHAIRMAN: The instance I had  
12 the price was definitely less for eight than for  
13 sixteen. It is just a question of whether the  
14 manufacturers have given enough attention to this  
15 question of the relative size of the package in  
16 which their products are sold, because frequently  
17 the druggist has not very much choice. They are  
18 done up in a certain size package and the package  
19 is prescribed and the druggist supplies the patient  
20 with that. The doctor knows they are in that size.  
21

22 MR. RICHARDSON: Some doctors will  
23 prescribe the original quantity regardless, but  
24 more often than not they will prescribe the quan-  
25 tity they want.

26 THE CHAIRMAN: And you will break the  
27 package of the medicine?

28 MR. RICHARDSON: That is right sir.  
29 I have one other comment on Mr. Mackenzie's brief.  
30 On page 6 of his brief, with regard to his suggestion,



1 or thought of "larger pure dispensaries" as he  
2 mentions it, "with an associated possible price  
3 saving to the consumer, and does it foster the  
4 condition of a small community outlet with its  
5 relatively higher cost of operation?" My thought  
6 there is that if the consumer wants the convenience  
7 and the service of a small community retail phar-  
8 macy, that this thought of the Government's for the  
9 larger dispensaries is not the answer entirely.  
10 Some people, some consumers will go to this centre  
11 area if it means a saving, but an awful lot of our  
12 customers want and ask and appreciate the service  
13 that the corner retail pharmacy can supply, and  
14 they are asking for some more various types of  
15 service, and expecting this in a community store,  
16 particularly in a metro area like Winnipeg. So  
17 that is my comment on his suggestion of a pure  
18 larger dispensary would not be the complete answer  
19 unless the consumer, the public, is willing to  
20 change their buying habit.

21  
22 THE CHAIRMAN: It would not be  
23 reasonable at all possibly in a small district?

24 MR. RICHARDSON: Not in a small  
25 district, no. In a metro district, if the consu-  
26 mer would change his habit, then this thought  
27 might be possible. That is it.

28  
29 MR. GREGORY: The Director of the  
30 School of Pharmacy has a comment or two to make with



1 respect to Dr. Nickerson's submission. Unfortunately,  
2 I am unable to tell you whether he will be expressing  
3 an opinion or dealing with facts.  
4

5 DR. J.R. MURRAY, sworn

6 DR. MURRAY: There is just one comment  
7 on Dr. Nickerson's submission yesterday. It was his  
8 opinion I believe that there were sufficient pharma-  
9 cists in Manitoba. In my opinion there are not  
10 sufficient pharmacists graduating from the University  
11 to take care of the requirements for graduate pharma-  
12 cists in this Province and in this country. I base  
13 this opinion on the number of requests we receive  
14 in our office for graduate pharmacists, especially  
15 in the Springtime before graduation. We get a number  
16 of notices of positions available, and in my experience,  
17 I have only been in Manitoba for almost two years, but  
18 in these two academic years we have had approximately  
19 the ratio of three positions available for each  
20 graduate. This indicates to me that there is a shor-  
21 tage of pharmacists in the Province.  
22

23 THE CHAIRMAN: That would apply  
24 chiefly in the smaller centres, would you say that  
25 the shortage in a city like Winnipeg or Brandon, or  
26 does that comment apply chiefly in a smaller town?  
27  
28  
29  
30





1 DR. MURRAY: Well, we get requests  
2 for graduate assistants both from the city and from  
3 the country. I have not broken this down.

4 THE CHAIRMAN: I just wondered  
5 whether you have enough graduates to fill the  
6 vacancies you hear about in the city.

7 DR. MURRAY: I would say no. I  
8 would say there are positions available for graduates  
9 in the city. Now, as well as the requests coming  
10 from retail pharmacy, a number of pharmacists also  
11 go into hospital pharmacy; there appear to be  
12 openings in the armed forces, there were about six  
13 openings for people in pharmacy. There are from  
14 time to time openings in the Dominion Government,  
15 the Food and Drug laboratories, the Civil Defence  
16 Organization. These positions are open to competi-  
17 tion between most pharmacists from all of Canada,  
18 but, nevertheless, jobs do exist. There are many  
19 pharmaceutical manufacturers who have positions  
20 available not only as detail men as medical service  
21 representatives, but a number of these firms have  
22 openings for pharmacists in their laboratories, and  
23 from time to time they have personnel officers  
24 coming out to interview possible candidates.

25 THE CHAIRMAN: Doctor, could you tell  
26 us about how many pharmacists graduate each year in  
27 the school?

28 DR. MURRAY: This year we had in the  
29  
30



1 graduating class 24 candidates; 22 were successful,  
2 and the other two I presume will achieve success in  
3 due course. Last year we had 16, next year we  
4 anticipate some 28, the following year some 20, and  
5 the year after that probably about 30.

6  
7 THE CHAIRMAN: The average looks as  
8 if it is going to be something like more than 20.

9 DR. MURRAY: Yes. But it will be  
10 increasing in future, because we are expanding our  
11 facilities. We have had a limited enrolment for  
12 the last few years because of lack of facilities.

13 THE CHAIRMAN: Is that because you  
14 have not been able to handle more, not having  
15 enough students?

16 DR. MURRAY: This is one of the  
17 causes. In future we will be able to enrol more  
18 students. Last year we had 55 students apply for  
19 entrance and we were only able to take 34. This  
20 year we will take 35, and next year we hope to be in  
21 our new premises and we hope to be able to enrol  
22 50 students.

23 THE CHAIRMAN: Perhaps the shortage  
24 will be over then.

25 DR. MURRAY: Yes, maybe in five years  
26 from now. But for the next five years I can antici-  
27 pate a shortage of pharmacists.

28 THE CHAIRMAN: You don't anticipate  
29 a shortage among those who apply for study in  
30



1 pharmacy?

2  
3 DR. MURRAY: No, this is not our  
4 experience in the last few years.

5 THE CHAIRMAN: You have a number of  
6 people who wish to be pharmacists, but if the faci-  
7 lities were there you could take more?

8 DR. MURRAY: Yes. Last year there  
9 were 55 applicants. I would anticipate a greater  
10 number this year based on the number we have had  
11 and the number we have had applying at that time.  
12 That is the only comment I have to make on Dr.  
13 Nickerson's submission.

14 THE CHAIRMAN: Any other comments?

15 DR. MURRAY: There is one other comment  
16 I could make perhaps on Mr. Mackenzie's submission.  
17 This was just an opinion. He mentioned the price of  
18 drugs, the prescriptions filled in hospitals were  
19 less than those filled in the retail pharmacy, and  
20 I would submit if the hospital pharmacy were put on  
21 a paying basis, if it were set up to pay its part  
22 of the overhead, that the cost of prescription in  
23 the hospital would be, except for sales tax and  
24 except for discounts available to the hospital through  
25 the purchase of large quantities of material, the  
26 price would not, the price difference would not be  
27 so great.  
28

29 THE CHAIRMAN: Of course, if they are  
30 not attempting to make any profit there would be



1 some difference.

2 DR. MURRAY: Yes, that is possible.

3 But if they are not charging for the day-to-day  
4 expenses like rent, heat, in this particular area,  
5 light and other facilities, then this tends to make  
6 the price less, whereas, in fact, this cost is  
7 being covered somewhere in the hospital.

8 THE CHAIRMAN: Yes, I think Mr.  
9 Mackenzie agreed that the hospital paid a part of  
10 the cost.

11 DR. MURRAY: I just wanted to bring  
12 that point up. I have no other comments, Mr.  
13 Chairman.

14 MR. WHITELEY: Doctor, do you know  
15 whether the situation in other schools of pharmacy  
16 in Canada so far as relationship between applicants  
17 and availability of providing for them is similar  
18 to your own?

19 DR. MURRAY: I don't have the recent  
20 figures for the number of people applying and the  
21 number who are accepted in the various colleges.  
22 I know at the University of Alberta - I should  
23 mention perhaps that I came here from the Univer-  
24 sity of Alberta in 1959, and in the years immediately  
25 prior to that time we had more applicants than we  
26 could handle with the facilities that were available.  
27 Since that time the facilities have been expanded  
28 in Alberta and they are able to enrol more students.  
29  
30



1 What percentage they are accepting from all those  
2 that apply I couldn't tell you. Enrolment has  
3 increased. It has increased in Saskatchewan,  
4 gradually going up; the University of Ontario has  
5 been rising very slowly, I believe, and I believe in  
6 British Columbia it is gradually going up. So  
7 there is an increase in the number of students, at  
8 the universities.  
9

10 But this shortage of pharmacists has  
11 been fairly widespread in the last two years  
12 throughout Canada and will, I submit, continue for  
13 at least another four or five years. Perhaps at  
14 that time our economy may expand and perhaps at  
15 that time we may not have caught up.

16 MR. GREGORY: Mr. Chairman, when I  
17 was dealing with page 3 of the Association brief  
18 yesterday afternoon, dealing with the paragraph  
19 where mention was made of the Code of Ethics in  
20 relationship to price and advertising, you raised  
21 a question at that time which I preferred not to  
22 answer in case my recollection, my preparation was  
23 not accurate. Mr. Anderson, the Registrar of the  
24 Association was not available for consultation  
25 until a very few minutes ago, and while our Director  
26 of the School was giving his views Mr. Richardson  
27 and Mr. Anderson were considering your question.  
28 I believe you asked for an example.  
29

30 THE CHAIRMAN: I wanted an example,





1 because I was anxious to find out what is meant in  
2 the mind of the Association by the term "unethical  
3 advertising" particularly in relation to price.

4 MR. GREGORY: Yes. If the gentlemen  
5 have completed their consultation, perhaps one of  
6 them would deal with the question.

7 MR. RICHARDSON: Sir, two examples  
8 of this idea of unethical advertising - one would  
9 be where a pharmacist advertised a price on a  
10 prescription with the idea that, for instance, on a  
11 two-dollar prescription you would give a package of  
12 razor blades, on a five-dollar prescription you  
13 would give a draw on a transistor radio or once a  
14 month you would give away a car on your prescrip-  
15 tion purchase. This isn't, we think, the best.

16 THE CHAIRMAN: Do you get much of  
17 that?

18 MR. RICHARDSON: No, we haven't had  
19 too much of that. There have been little bits of  
20 it, and usually talking to the individual members  
21 we made them realise from a professional standpoint  
22 if they wished to give a lower price that is their  
23 prerogative, but it should be with no gimmicks  
24 attached, that they should be able to offer whatever  
25 low-price they wish to the consumer without the  
26 consumer having to buy anything else or having to  
27 receive anything else.

28 THE CHAIRMAN: Your comments apply  
29  
30



1 particularly to prescription items?

2 MR. RICHARDSON: This is with regard  
3 to prescriptions, yes.

4 THE CHAIRMAN: I was going to make  
5 the comment that if many of your members were able  
6 to give away a car a month you would be doing all  
7 right.

8 MR. RICHARDSON: It is a question of  
9 the gimmick attached to the price of prescriptions  
10 which we think should not be sold.

11 The second example, which so far here  
12 has not shown up to any great extent, would be with  
13 this sort of generic drugs where a pharmacist might  
14 advertise that he had the best price on generic  
15 drugs without thinking of the quality of the product.  
16 That would not be in the best interests of the public.

17 THE CHAIRMAN: Would you object to  
18 that type of advertising if he is selling identically  
19 the same product as others? Would you object on the  
20 ground that it is unethical advertising to advertise  
21 a claim that the advertising druggist was selling at  
22 the lowest prices available in town or lower than  
23 anyone else in town?

24 MR. RICHARDSON: No. If his prescrip-  
25 tion was so written that the pharmacist could supply  
26 a drug of his choice, as long as he could supply a  
27 good part, our Association would have no comment on  
28 his price as long as he had the welfare of the  
29  
30



1 consumer in mind.

2 THE CHAIRMAN: I was wondering what  
3 you meant by this term. As I explained yesterday,  
4 the word "ethical" or "unethical" has a number of  
5 different meanings. If you have an ethical druggist,  
6 it may be that the drugs he sold were ethical and  
7 he may not be ethical.  
8

9 Anything further you wish to add?

10 MR. RICHARDSON: No, sir.

11 MR. WHITELEY: What would be the posi-  
12 tion if a drug is advertised where you are prepared  
13 to give discount on cash and carry?

14 MR. ANDERSON: Well, sir, you have  
15 phrased that question a little different from what  
16 my answer is going to be. I believe it would be  
17 regarded unethical advertising if they advertised  
18 a discount on prescription pricing, because who  
19 knows what the prescription price will be until the  
20 prescription is dispensed, and when there is no  
21 uniform enforceable fee, what is the person receiving  
22 the discount from?  
23

24 MR. WHITELEY: I was thinking of a  
25 situation if a druggist says: "You want this delivered  
26 to your house. If you come and get it I will take  
27 some off".  
28  
29  
30



1 MR. ANDERSON: My point is when you  
2 have no mandatory scale of fees, what is the custo-  
3 mer receiving a discount from? It is an unknown  
4 quantity, sir.

5 MR. WHITELEY: Not if the revenue  
6 supports the price.

7 MR. ANDERSON: Apparently I didn't  
8 catch what you said.

9 MR. WHITELEY: I said: if the druggist  
10 says if you have this delivered to your house it is  
11 so much and if you come to the store it is so much  
12 less.

13 MR. ANDERSON: Well, I don't think  
14 there would be any comment in that regard because  
15 that is a cash-and-carry proposition.

16 If they add additional service  
17 charges to the price of the prescription I think  
18 that certainly does not constitute unethical prac-  
19 tice.

20 MR. WHITELEY: The point I am making  
21 is: if you advertise that situation.

22 MR. ANDERSON: He would have to just  
23 advertise his price of his prescriptions and that  
24 would be rather a difficult thing to do. He doesn't  
25 know what each prescription will be written for;  
26 what is wanted.

27 THE CHAIRMAN: If there is more or  
28 less a standard product that is asked for frequently  
29  
30



1 I suppose he may advertise one or two of those if  
2 he has a certain amount of calls and can count on  
3 them. He knows what the prescription will be. He  
4 could say what the price of that particular thing  
5 would be. He could advertise it if he wanted to.  
6 Your contention is that he could not advertise that  
7 all prescriptions will be at a certain price if you  
8 call for them at the store because there are so  
9 many different kinds of prescriptions at different  
10 prices, he couldn't advertise it effectively. Is  
11 that it?  
12

13 I think the question Mr. Whiteley was  
14 asking was if you found out, would the Association  
15 object to that kind of advertising on the ground it  
16 was unethical; not whether it would be a difficult  
17 thing for him to do. Would the Association object  
18 to the druggist advertising in that way?  
19

20 He could advertise simply this way:  
21 if you come to the store the price for any prescrip-  
22 tion will be 25 cents less than if it is delivered  
23 to your house; a general statement of that kind  
24 would apply to whatever price the prescription would  
25 be. Would there be any objection to that?

26 MR. ANDERSON: The situation has never  
27 arisen, sir, but I don't think, as you have explained  
28 it, there would be exception taken on the part of  
29 the Association to that type of advertising. I think  
30 this is more designed for a broad statement of





1 discounts where the public are not informed as to  
2 what they are receiving a discount from. I think  
3 that is the intent here. It is an unknown quantity -  
4 what a discount has been given for.

5  
6 THE CHAIRMAN: I wonder if this  
7 situation could happen. The druggist gets a sugges-  
8 ted list price and says my price will be 10% below  
9 the suggested list price which is available. I don't  
10 know whether that situation could happen.

11 MR. ANDERSON: Sir, I think in answer  
12 to your question you are correct. He would have to  
13 publish with his promises the list price of whatever  
14 the prescription would be from which he was giving a  
15 discount; in fairness to the public, sir.

16 THE CHAIRMAN: Thank you, Mr. Anderson.

17 MR. GREGORY: I don't believe these  
18 gentlemen have any further statements to make, Mr.  
19 Chairman. They would be quite prepared to deal with  
20 any questions that may arise from our brief and its  
21 annexes.

22 THE CHAIRMAN: Mr. MacLeod, have you  
23 any questions arising out of the brief?

24 MR. MACLEOD: A few, Mr. Chairman. A  
25 number of these will be relating to the operations  
26 of the drugstores. Perhaps I can address my ques-  
27 tions to Mr. Richardson.  
28  
29  
30



1 DIRECT EXAMINATION BY MR. MACLEOD:

2 First of all, the Manitoba Pharmaceu-  
3 tical Association is a statutory body; is that not  
4 so?  
5

6 MR. RICHARDSON: Yes sir.

7 MR. MACLEOD: There is a separate body  
8 in the nature of a trade association. I think it is  
9 referred to in the brief. What is that?

10 MR. RICHARDSON: The Manitoba Retail  
11 Druggists' Association. Is that the one to which you  
12 are referring?

13 MR. MACLEOD: Yes. Is there any other  
14 association of retail druggists in Manitoba, to your  
15 knowledge?

16 MR. RICHARDSON: There is the A.R.D.,  
17 Associated Retail Druggists.

18 MR. MACLEOD: Is your firm a member of  
19 any of these associations?

20 MR. RICHARDSON: Yes. I am a member  
21 of both.

22 MR. MACLEOD: Of all three; the statu-  
23 tory and the two others?

24 MR. RICHARDSON: Yes. The Pharmaceu-  
25 tical Association is compulsory. The other two are  
26 voluntary.

27 MR. MACLEOD: You are a member of the  
28 other two?  
29

30 MR. RICHARDSON: Yes.



1  
2 MR. MACLEOD: What functions do the  
3 other two respectively perform?

4 MR. RICHARDSON: The M.R.D.A., the  
5 Manitoba Retail Druggists' Association deals with  
6 merchandising methods, promotions, advice that they  
7 can give to the retail pharmacists.

8 This Association gives suggestions  
9 and advice to the retail pharmacist, not the hospital  
10 pharmacist; strictly merchandising.

11 MR. MACLEOD: Advice in respect to  
12 what matters?

13 MR. RICHARDSON: Methods of merchan-  
14 dising.

15 MR. MACLEOD: Can you give us an  
16 example of that?

17 MR. RICHARDSON: It has been sugges-  
18 ted by the Manitoba Retail Druggists' Association  
19 to manufacturers that the pharmacist would be  
20 possibly and presumably would be better off if  
21 there were not even gimmicks attached to tooth-  
22 paste and all this sort of thing, and that is the  
23 Association referred to there.

24 The Retail Druggists' Association  
25 is trying to promote a cleaner method of merchan-  
26 dising so that we can keep our stocks in better  
27 shape.  
28

29 As it has been - again going back  
30 to the toothpaste episode - it has not been



1 uncommon in the last two or three years for us to -  
2 by us I mean the retailers - to have six or seven  
3 different prices for the sizes of an item in stock.  
4 Again I might mention toothpaste.  
5

6               There will be the regular size; they  
7 will come out with "specials" with either a flash-  
8 light attached or a hairbrush attached or five cents  
9 off or ten cents off and as a result our inventory  
10 is quite often doubled. That is the sort of  
11 advice that M.R.D.A. is trying to pass on to the  
12 retail pharmacists.

13               MR. MACLEOD: In the situation of  
14 which you spoke and the illustration using tooth-  
15 paste, it would seem to be a matter for the manu-  
16 facturers, would it not? Could your Association  
17 speak on your behalf to the manufacturers?

18               MR. RICHARDSON: Yes, and they have  
19 done so.

20               MR. MACLEOD: Would they make repre-  
21 sentations all along the line with different  
22 products; where the need arose?  
23

24               MR. RICHARDSON: Yes, where the need  
25 had arisen they have done so.

26               MR. MACLEOD: Is that the principal  
27 function of that particular Association?

28               MR. RICHARDSON: Yes sir.

29               MR. ANDERSON: As well as bringing in  
30 information relative to modern-day methods of



1 modernization in stock-keeping and stock control  
2 and in general business promotion.

3 MR. MACLEOD: The second trade associa-  
4 tion which you have mentioned - what does it do?

5 MR. RICHARDSON: To explain this in  
6 a word is a bit difficult but this deals with price,  
7 advertising more of various products; whereas the  
8 M.R.D.A. cannot advertise the price or promote the  
9 price. A.R.D. can advertise what is available in  
10 the retail store at a certain price.

11 MR. MACLEOD: Does the Association  
12 insert advertising on behalf of the ---

13 MR. RICHARDSON: Of the membership  
14 of the A.R.D.

15 MR. MACLEOD: Rather than ---

16 MR. RICHARDSON: Mr. Anderson pointed  
17 out that the A.R.D. is a limited company.

18 MR. MACLEOD: Does it itself deal with  
19 drug products or sundry products?

20 MR. RICHARDSON: It doesn't sell  
21 itself, no. It is just an advertising.

22 MR. MACLEOD: And it advertises on  
23 behalf of the retail druggists in Manitoba?

24 MR. RICHARDSON: Yes.

25 MR. MACLEOD: Under its own name. It  
26 says "Go to the drugstore and you can get this for  
27 a certain price".

28 MR. RICHARDSON: "Go to your A.R.D.





1 pharmacist".

2 THE CHAIRMAN: Do all retail druggists  
3 belong to the A.R.D.?

4 MR. RICHARDSON: No sir. It is volun-  
5 tary.

6 THE CHAIRMAN: Have you any idea what  
7 proportion of them do belong?

8 MR. RICHARDSON: In Manitoba?

9 THE CHAIRMAN: Yes.

10 MR. RICHARDSON: I haven't got the  
11 figures, sir, but I think approximately 50%.

12 MR. HOLLAND: I think it would be a  
13 bit over that.

14 THE CHAIRMAN: 50% and more.

15 MR. RICHARDSON: Yes. The greater  
16 proportion of the membership is in Greater Winnipeg.

17 THE CHAIRMAN: What about M.R.D.A.?

18 MR. RICHARDSON: The M.R.D.A. has  
19 almost complete membership of retail pharmacists.

20 THE CHAIRMAN: And the A.R.D. is  
21 limited. I understand from your evidence it adver-  
22 tises on behalf of its members.

23 MR. RICHARDSON: Yes sir.

24 THE CHAIRMAN: It is in a sense an  
25 advertising agency for its members?

26 MR. RICHARDSON: Yes, it could be.

27 THE CHAIRMAN: Where it advertises  
28 prices, those are the prices that its members have  
29  
30



1 agreed to charge or have agreed among themselves or  
2 have come to accept that they will charge?

3 MR. RICHARDSON: Generally they are  
4 prices acceptable by the general membership, yes,  
5 and oftentimes - as a matter of fact in a great  
6 proportion of the times they are the prices suggested  
7 by the manufacturers.  
8

9 The exception would be a special of  
10 some sort that was purchased for our group; a thermo-  
11 meter, hot water bottle, a special purchase of a  
12 special item where it was advertised at a certain  
13 price available at the A.R.D. store.

14 THE CHAIRMAN: Who would buy for the  
15 whole group?

16 MR. RICHARDSON: Sir, there is an  
17 executive on the A.R.D. A bulletin from them comes  
18 out periodically to the membership of the A.R.D.  
19 advising them what the executive have done or are  
20 doing; what purchases are available and then if it  
21 is a special purchase it is made available to the  
22 individual member. They do not sell. The A.R.D.  
23 does not sell material.  
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THE CHAIRMAN: The A.R.D. bulletin would describe an item which may be purchased specially? :

MR. RICHARDSON: Yes.

THE CHAIRMAN: And it would suggest a price at which it might be sold?

MR. RICHARDSON: Yes, usually a special or often a special price, low mark-up, which is the drawing part sort of thing of the suggested prices.

THE CHAIRMAN: Would each individual member or druggist be able to buy this item at the special item price?

MR. RICHARDSON: They can, but they don't have to. The opportunity is there.

THE CHAIRMAN: Each individual druggist may make a separate order?

MR. RICHARDSON:: Yes, we can order one dozen or three dozen, whatever we think we can dispose of.

THE CHAIRMAN: Would that be available only to members of the A.R.D., or could other druggists who heard about it acquire the same product at that price?

MR. RICHARDSON: Generally, I might be wrong in this, I would almost think that the method of our purchasing this, that this might be available to other non-members.

THE CHAIRMAN: I am just wondering



1 what interest the manufacturers would have in not  
2 making it available to non-members when each druggist  
3 buys individually anyway.

4 MR. MACLEOD: Have we covered the  
5 work of the M.R.D.A.?

6 MR. RICHARDSON: The M.R.D.A., yes,  
7 that was the first one you asked me, it was merchan-  
8 dising. Manitoba Retail Druggists' Association.

9 MR. MACLEOD: Is there a local associa-  
10 tion of druggists for the Winnipeg or metropolitan  
11 area?

12 MR. RICHARDSON: No sir.

13 MR. MACLEOD: Under the Pharmacy Act it  
14 is required that each pharmacy be in charge of a  
15 licenced pharmacist?

16 MR. RICHARDSON: That is right.

17 MR. MACLEOD: And does that work out  
18 in practice, when the owner has to be absent from  
19 the store do you have to have a qualified pharmacist  
20 on duty?

21 MR. RICHARDSON: Yes sir.

22 MR. MACLEOD: Under the Manitoba  
23 Pharmacy Act, is there any restriction on companies  
24 as there is in some other provinces? For instance,  
25 in some other provinces before a company may operate  
26 a pharmacy the majority of its shares must be held  
27 by qualified pharmacists.

28 MR. RICHARDSON: That is not so in  
29  
30



1 Manitoba.

2 MR. MACLEOD: The company simply has  
3 to engage qualified pharmacists?

4 MR. RICHARDSON: Yes.

5 THE CHAIRMAN: That would be a company  
6 like the T. Eaton Company or the Hudson's Bay Company  
7 could operate a pharmacy?

8 MR. RICHARDSON: Yes sir.

9 MR. MACLEOD: In a store where the  
10 owner is not able to, perhaps it is too large and  
11 he is not able to give it his full attention, does  
12 he work on shifts with his registered pharmacists?

13 MR. RICHARDSON: Generally speaking,  
14 yes.

15 MR. MACLEOD: It is arranged so that  
16 one will be in the store at all times?

17 MR. RICHARDSON: Yes.

18 MR. MACLEOD: In practice, how strict  
19 is the rule? May a pharmacist leave for lunch or for  
20 five minutes?

21 MR. RICHARDSON: We try to be quite  
22 strict. Personal experience, when I opened my store,  
23 for three years I had no help and I ate in the store,  
24 and if I didn't have a girl or a boy to send to the  
25 bank, I closed the store to go to the bank. There  
26 are minor exceptions made now for a few minutes out  
27 of the store, but generally we try to control it.

28 MR. MACLEOD: And there are certain  
29  
30





1 restrictions on the sale of drugs, or drug products,  
2 in Manitoba, are there not?

3 MR. RICHARDSON: In what respect?

4 MR. MACLEOD: That only drugstores may  
5 sell them, or pharmacies?

6 MR. RICHARDSON: Yes.

7 MR. MACLEOD: Glancing through this  
8 thing, the Consolidation of the Manitoba Pharmaceu-  
9 tical Act, it would appear that no one within three  
10 miles of a drugstore may sell aspirin for example,  
11 is that correct?

12 MR. ANDERSON: That is a typographical  
13 error I am sorry to say. That has now been deleted.

14 MR. MACLEOD: Is the whole of Part 3  
15 of Schedule B deleted, or just aspirin deleted out  
16 of it?

17 MR. ANDERSON: Just the aspirin  
18 deleted.

19 MR. MACLEOD: So, taking the second  
20 one which is listed, tincture of iodine, no one but  
21 a druggist may sell that in any area within three  
22 miles of a drugstore, is that correct?

23 MR. RICHARDSON: I might say, sir,  
24 we are at the present time working on amendments to  
25 these schedules with the release of some of these  
26 items and enforcement of others. This is under  
27 consideration at the present time, to bring it up  
28 to date with today's thinking. This question of  
29  
30



1  
2 iodine that you mentioned isn't at the moment  
3 enforced by our Association.

4 THE CHAIRMAN: Does your Association  
5 have complete control over the lists in the Schedules,  
6 or is it done by the Legislature?

7 MR. ANDERSON: Yes, it may be confirmed  
8 by Order in Council.

9 THE CHAIRMAN: It is done by Order in  
10 Council, and you apply for any changes and it is  
11 approved by Order in Council?

12 MR. ANDERSON: That is right.

13 MR. MACLEOD: Do you know if the  
14 product Metrecal is sold in outlets other than drug-  
15 stores in Winnipeg?

16 MR. RICHARDSON: I haven't seen Metre-  
17 cal sold in any other outlets.

18 MR. MACLEOD: Is it a policy, do you  
19 know, of Mead Johnson and Company, or Donald Dalton  
20 Division, or whatever it is now, to confine its  
21 sale of products to drugstores?  
22

23 MR. RICHARDSON: I think that is their  
24 thought.

25 MR. MACLEOD: Do you know if the  
26 product Pabulum is only sold in drugstores?

27 MR. RICHARDSON: No, it is not.

28 MR. MACLEOD: Do you recall your  
29 Association making any representations in years past  
30 that its sale should be confined to drugstores?



1 MR. RICHARDSON: Personally I don't  
2 remember actually on Pabulum.

3 MR. ANDERSON: I believe there were  
4 representations made.

5 MR. MACLEOD: Is it not a fact that  
6 representations were made, and the manufacturer was  
7 threatened with a boycott if he made this product  
8 available to other outlets than drugstores?  
9

10 MR. ANDERSON: I have no knowledge of  
11 the boycott, not from this Association.

12 MR. MACLEOD: Is it the general policy  
13 of the so-called large ethical drug manufacturers to  
14 restrict their products to drugstores?

15 MR. GREGORY: Mr. Chairman, I don't  
16 object to Mr. MacLeod's line of questioning, but any  
17 knowledge that these people have would of necessity  
18 be hearsay knowledge.

19 THE CHAIRMAN: I am not too sure. One  
20 or two of them are practising pharmacists, and they  
21 would know if they buy the product from the manufac-  
22 turer, whether that manufacturer tells them that they  
23 are the only people who are sold these goods. To  
24 that extent they can give the information.

25 MR. GREGORY: They can speak from their  
26 experience, but I don't think they could really  
27 inform the Commission what the policy of some manu-  
28 facturer is.  
29

30 THE CHAIRMAN: They can say to the



1 extent that they only get it from certain manufac-  
2 turers.

3 MR. GREGORY: Yes, I would like the  
4 record to state that.

5 THE CHAIRMAN: They might have a state-  
6 ment or record of the company, or something of that  
7 sort.  
8

9 MR. MACLEOD: Does not Frosst for  
10 instance advertise to druggists on the basis: "Handle  
11 our products because they are only available to drug-  
12 stores"?

13 MR. RICHARDSON: My answer to that  
14 would be, when you say advertise, word of mouth  
15 advertising possibly yes, by the detail man. At the  
16 moment I don't remember seeing a printed statement  
17 from Frosst to that effect, as expressed by yourself.

18 MR. MACLEOD: Isn't it within your  
19 knowledge that the products of perhaps most of the  
20 large ethical drug manufacturers are only made  
21 available to drugstores?  
22

23 MR. RICHARDSON: I would answer, sir,  
24 that in possibly a lot of cases that is so, or they  
25 try to make it so.

26 MR. MACLEOD: I am going to try to  
27 paraphrase a statement, a suggestion that was made  
28 to the Commission on a previous hearing, and ask  
29 you if your experience indicates that it is correct  
30 or otherwise. It was suggested to the Commission



1 by a witness that there are certain products for  
2 which a prescription is not required by law, but  
3 which the druggist will not sell except on prescrip-  
4 tion because he is instructed not to sell. Have you  
5 any knowledge of a situation like that?  
6

2 7 MR. RICHARDSON: Would you repeat that,  
8 sir, it is a little involved?

9 MR. MACLEOD: It was suggested that  
10 there are certain drug products for which a pres-  
11 cription isn't legally required. In other words,  
12 they are not under Schedule F in the Manitoba Phar-  
13 macy Act. You could sell them over the counter, but  
14 it has been suggested that they do not be sold over  
15 the counter because the manufacturer says they  
16 should not be sold except on prescription.

17 MR. RICHARDSON: No sir, our Associa-  
18 tion does not condone that sort of thing at all.  
19 We buy by the laws as they are, the Federal Food and  
20 Drug Act, the Narcotics Act, but we take no cogni-  
21 sance of anything a manufacturer might say otherwise.  
22

23 MR. MACLEOD: I think the witness who  
24 made this suggestion was a doctor, and he was under  
25 the impression that in certain cases it was necessary  
26 that he write a prescription, even though not required  
27 by law, but at least in Manitoba if he were to state  
28 to his patient: "Go to the drugstore and get 'X'  
29 product", the patient would be provided with it?  
30

MR. RICHARDSON: Yes, if it is not





1 listed under Federal or Provincial law as requiring  
2 prescription.

3 THE CHAIRMAN: In your experience do  
4 manufacturing companies request that you do not  
5 sell certain products except under prescription,  
6 even though you may not comply with the request, do  
7 you get that sort of request from manufacturers?

8 MR. RICHARDSON: No sir, I have never  
9 received that request personally.

10 MR. MACLEOD: Are prescriptions some-  
11 times written for drugs and medicinals for which a  
12 prescription is not legally required?

13 MR. RICHARDSON: Yes sir.

14 MR. MACLEOD: Would that be true of  
15 most drugs and medicinals, except patent medicines?  
16 In other words, in your experience would you find  
17 that virtually every type of drug, except the  
18 patent medicines, would be prescribed at one time  
19 or another?

20 MR. RICHARDSON: Well, other than  
21 patent medicines they have been prescribed at one  
22 time or another, but not necessarily sold today.  
23 By that I mean as the public learns about things  
24 and often today the doctor will suggest to the  
25 patient that he go and buy a certain thing, we are  
26 receiving more requests by the public for some of  
27 these products that are not patented expressly.

28 MR. MACLEOD: I was wondering about  
29  
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1 the application of Section 3(e) of the Code of  
2 Ethics, which says:

3 "A pharmacist shall not in any adver-  
4 tising nor in any solicitation to a prescriber or  
5 group of prescribers, make any reference to price  
6 for compounding and/or dispensing of prescriptions  
7 or for any drugs or medicinals that may be used in  
8 prescriptions".  
9

10 What I am getting at is, does the  
11 fact that most drugs or medicinals, except patent  
12 medicines, may at one time or another be the subject  
13 of a prescription, does that fact, in conjunction  
14 with Section 3(e) of the Code of Ethics virtually  
15 prohibit the advertising of any drug?

16 MR. RICHARDSON: By our members do  
17 you mean?

18 MR. MACLEOD: Yes, the price for  
19 compounding, or for any drug or medicinal?  
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MR. MACLEOD: Let me put it to you this way. Is the result of Section 3(e) against the background we have been discussing that you may not advertise virtually any drug, you may not advertise a price for it?

MR. RICHARDSON: Was that your question, sir, could we advertise a price that was not being dispensed or compounded?

MR. MACLEOD: What I was getting at was the meaning of what is used in prescriptions.

MR. RICHARDSON: I think the thought here is that an item that may be used but is not necessary to have a prescription, that item could be advertised.

MR. MACLEOD: Your reading of Section 3(e) then is that it is confined to drugs on the prescription list?

MR. RICHARDSON: No, I believe the thought here is if it is prescribed and sent regardless of the restricted list.

THE CHAIRMAN: If it is, in fact, prescribed.

MR. RICHARDSON: I beg your pardon, sir?

THE CHAIRMAN: If it is, in fact, prescribed, you mean, it may not be advertised?

MR. RICHARDSON: If it is prescribed, if this particular item or prescription is prescribed,



1 that is the prescription itself.

2 THE CHAIRMAN: But the question was  
3 whether a particular drug which may or may not be  
4 prescribed, that is legally it may be sold without  
5 a prescription and it may be sold under a prescrip-  
6 tion, whether a druggist may advertise a price for  
7 that drug.  
8

9 MR. RICHARDSON: If it can be sold  
10 legally without a prescription, then it could be  
11 advertised.

12 THE CHAIRMAN: That is your view?

13 MR. RICHARDSON: That is my thought,  
14 yes.

15 MR. MACLEOD: What code is used for  
16 marking prescriptions for the purposes of paragraph  
17 6 on the dispensing fee schedule? Have you the  
18 dispensing fee schedule in front of you? If I may  
19 just read paragraph 6 for the record: "The practice  
20 of quoting prices on all copies of prescriptions to  
21 patients should be followed even if only a price is  
22 asked for on new prescriptions".  
23

24 MR. RICHARDSON: This suggestion is a  
25 national coding.

26 MR. MACLEOD: What is the code?

27 MR. RICHARDSON: Pharmacists.

28 MR. MACLEOD: With respect to the  
29 letters 19 to 0.

30 MR. RICHARDSON: Yes, with one change.



1 MR. MACLEOD: In the Code of Ethics  
2 we find in 3(f) that a pharmacist shall not delibe-  
3 rately under-price a prescription or a copy for the  
4 purpose of injuring the reputation or fair dealing  
5 of other pharmacists. Would failure to follow the  
6 price code of a prescription be considered a viola-  
7 tion of 3(f)? It is taken to one pharmacist, he  
8 puts a code upon it. Supposing he fills it and puts  
9 his price on the code, and if that prescription is  
10 taken to a second pharmacist and he decides to put  
11 a lower price, would he be considered to be violating  
12 the Code of Ethics?  
13

14 MR. RICHARDSON: Not necessarily.

15 MR. MACLEOD: What are your qualifica-  
16 tions for that answer?

17 MR. RICHARDSON: The Code reads:  
18 "deliberately under-pricing for the purpose of inju-  
19 ring the reputation or fair dealing of other pharma-  
20 cists".

21 MR. MACLEOD: Yes.

22 MR. RICHARDSON: If for some parti-  
23 cular reason there was an exception, where the  
24 pharmacist was friendly to the customer or some  
25 other personal reason, he may be doing it for his  
26 own personal reasons, not for the purpose of  
27 injuring the other pharmacists.  
28

29 MR. MACLEOD: What would you say if  
30 he made a practice of taking 25 cents or 50 cents





1 off the price of a prescription which was brought  
2 to him in that way?

3 MR. RICHARDSON: If it was known and  
4 could be proved that he was doing this consistently,  
5 yes, it would be considered a violation, I believe.  
6

7 MR. MACLEOD: Even though he might  
8 consider he was making sufficient profit on those  
9 prescriptions he was filling to operate?

10 MR. RICHARDSON: I think the thought  
11 might be what were his normal methods of pricing.  
12 Was he deliberately cutting the price to injure the  
13 first pharmacist, or whether these were always his  
14 regular methods of pricing?

15 MR. MACLEOD: Do you know of any  
16 instance arising under this particular sub-section  
17 of the Code of Ethics?

18 MR. RICHARDSON: No, sir.

19 MR. MACLEOD: Do you know the number  
20 of drugstores in Winnipeg, even approximately?

21 MR. RICHARDSON: 191 in Greater Winni-  
22 peg, 116 outside of Greater Winnipeg.

23 THE CHAIRMAN: That is for the Province  
24 of Manitoba?

25 MR. RICHARDSON: Yes.

26 THE CHAIRMAN: 191 in Greater Winnipeg;  
27 that is what you call the metropolitan area?

28 MR. RICHARDSON: Yes. I am sorry, sir,  
29 this figure would not be necessarily retail outlets.  
30



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1 This figure I have given you is for licenced premises.  
2 We haven't got a breakdown here. About 174 would be  
3 the number of retail outlets in Greater Winnipeg.

4 MR. MACLEOD: And in your own - do  
5 you operate a single store or chain?

6 MR. RICHARDSON: A single store.

7 MR. MACLEOD: In your own store what  
8 percentage of your sales are accounted for by  
9 prescriptions?

10 MR. RICHARDSON: Between 23% and 24%  
11 last year.

12 THE CHAIRMAN: Is that a fairly normal  
13 experience for you or does it vary greatly from  
14 year to year?

15 MR. RICHARDSON: No, this possibly is  
16 a slight decline from a couple of years ago, pretty  
17 well at 25%, just a slight decline over the last  
18 couple of years.

19 MR. MACLEOD: What is the going wage  
20 of a pharmacist, starting as a boy, for instance?

21 MR. RICHARDSON: For a new graduate?

22 MR. MACLEOD: Yes.

23 MR. RICHARDSON: I would say \$115  
24 would be minimum and possibly \$125 is not unusual.

25 MR. MACLEOD: Would it be normal for  
26 that to be increased within a few years as he  
27 gained experience?

28 MR. RICHARDSON: That I think would



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1 depend on the individual and the manager of the  
2 business, the value of that man to that business.

3 THE CHAIRMAN: That was the wage per  
4 week, was it?

5 MR. RICHARDSON: Yes, sir.

6 MR. MACLEOD: Now, are you and any  
7 qualified pharmacist who may be employed by you  
8 continuously engaged in filling prescriptions? Is  
9 there that much prescription business in your store?

10 MR. RICHARDSON: No, sir.

11 MR. MACLEOD: Do you or any qualified  
12 pharmacist who may be engaged by you spend a good  
13 deal of your time selling straight merchandise in  
14 the front store?

15 MR. RICHARDSON: We spend some time,  
16 yes. I haven't figured out the portion of time.

17 MR. MACLEOD: That is a pretty serious  
18 economic waste, isn't it, to have a \$115, \$125 a  
19 week clerk selling bubble gum and cigarettes and  
20 hairnets?

21 MR. RICHARDSON: This, sir, involves  
22 quite a number of things. Our law demands it, and  
23 the consumer wants it.

24 MR. MACLEOD: Do you read the Canadian  
25 Pharmaceutical Journal?

26 MR. RICHARDSON: Yes, sir.

27 MR. MACLEOD: Do you recall the  
28 February, 1961, issue which had a lead article: "Do  
29  
30



1 retail pharmacists ~~deserve~~ the professional status",  
2 by G. Alan Robinson, who I believe is a professional  
3 pharmacist in the United States, and comments by a  
4 number of men in the pharmaceutical field in Canada.  
5 Do you recall reading that article?  
6

7 MR. RICHARDSON: I don't remember  
8 reading it, sir. No, sir, I didn't read that.

9 MR. MACLEOD: I would just like to  
10 have an expression of view from a practising pharma-  
11 cist. This article takes the view that retail  
12 pharmacists are simply merchants and quotes at some  
13 place where you are the only merchants who must have  
14 college degrees. Is it a fact or not that a large  
15 part of dispensing done in pharmacies today is  
16 simply putting out ready-made items into the quanti-  
17 ties prescribed by the physician?  
18

19 MR. RICHARDSON: I would like to take  
20 exception to that question when you use the word  
21 "simply".

22 MR. MACLEOD: I just want your views  
23 on the record.

24 MR. RICHARDSON: If you are asking  
25 whether the bulk of dispensing is the use of pre-  
26 pared items, tablets, liquids, rather than actual  
27 compounding, the answer is yes, but I do not  
28 consider it a simple operation of pouring from one  
29 bottle to another, counting tablets from one bottle  
30 to a box; it is not that simple.



dpw  
1 MR. MACLEOD: Well, perhaps you could  
2 just expand on that. This is the information that  
3 the Commission wants.  
4

5 MR. RICHARDSON: First of all on  
6 receipt of a prescription, the pharmacist must read  
7 it and understand the intent of the prescription.

8 THE CHAIRMAN: That is sometimes  
9 rather difficult, is it not, to read it?

10 MR. RICHARDSON: Yes, it is, sir, and  
11 that is part of this business "It is not so simple"

12 We read the prescription, the item,  
13 the quantity and the dose. We take cognisance of  
14 the date, the customer and the doctor.

15 If we can see no apparent discrepancy  
16 in the prescription then it will be filled.

17 Our training is such that when we  
18 handle an item, we observe the label on that item  
19 at least three times to make sure or try to eliminate  
20 any possibility of error. We consider the dosage.  
21 It is not too unusual for a physician to make an  
22 error or prescribe what we might consider a larger  
23 than normal dose.  
24

25 It is our responsibility to check  
26 this dosage and if we are sure it is a definite  
27 error we will contact the physician and tell him  
28 what he has written, and ask him if that is what he  
29 wants.

30 If he assures us that is the dosage





1 he wants, we will make a notation on the prescrip-  
2 tion we have contacted the doctor regarding this  
3 dose; the reason for our filling that dosage. We  
4 might even have him sign this particular dosage a  
5 second time. Doctors and physicians are busy and  
6 whereas they do not make this error too often, it  
7 is possible.

8  
9 THE CHAIRMAN: It does happen?

10 MR. RICHARDSON: It does happen. I  
11 have an item in mind that happened to my own store  
12 not too long ago where I received a prescription  
13 for an item called medomin, 400 milligrammes. This  
14 is a sedative and hypnotic. Dosage one, four times  
15 a day, 1,600 milligrammes a day.

16 The average dose would be one 200  
17 milligramme tablet. One or two tablets at bedtime  
18 would be a normal dosage.

19 This tablet was not available in 400-  
20 milligramme strength and the doctor had prescribed  
21 1,600 milligrammes a day. The normal maximum would  
22 be 200 to 400 milligrammes. I read the prescription  
23 and asked the other pharmacist on duty with me to  
24 also read it and he deciphered it the same way.

25  
26 I contacted the physician and he was  
27 very apologetic. He didn't intend to write medomin.  
28 He intended to write meprobanate. It was a slip on  
29 his part but it could have had bad results.

30 This doesn't happen every day but that



1 is the sort of thing where our responsibility lies  
2 and that is why I say it is not simply pouring out  
3 of one bottle to another. All these factors are  
4 involved.  
5

6 THE CHAIRMAN: I suppose in some  
7 cases where the doctor prescribes some tablets that  
8 are already made up, there is not much difficulty  
9 about its selection. In fact I have seen a druggist  
10 simply take a bottle from a case, steam off the  
11 label from the manufacturer and place his own label  
12 with the prescription number on it and hand it to  
13 the customer. In fact, I have been the customer  
14 and that has happened. Then all he does is identify,  
15 surely, the prescription with the bottle.

16 MR. RICHARDSON: That is right, sir.

17 THE CHAIRMAN: In many instances it  
18 is very simple but, of course, as you say, you are  
19 responsible as a pharmacist for at least selecting  
20 the right bottle.  
21

22 MR. RICHARDSON: Yes sir and to make  
23 sure that the dose that I type on that label, even  
24 though it is put on as a provisional container, is  
25 the proper accepted dosage for that particular item.

26 THE CHAIRMAN: The accepted dosage  
27 and if the dosage prescribed differs from what is  
28 the generally accepted dosage, you then get in touch  
29 with the doctor?

30 MR. RICHARDSON: Yes sir. He may, for



1 some particular reason, want an exceptional dosage  
2 for that particular patient but it is our duty to  
3 know that; that he has prescribed for a reason.

4 THE CHAIRMAN: And that is so whether  
5 or not in your opinion the larger dose is definitely  
6 dangerous?  
7

8 MR. RICHARDSON: Yes sir.

9 MR. MACLEOD: Do you follow the dispen-  
10 sing fee schedule in the pricing of the prescriptions?

11 MR. RICHARDSON: Yes sir.

12 MR. MACLEOD: Do you know if it is  
13 generally followed in the City of Winnipeg?

14 MR. RICHARDSON: I don't know what  
15 proportion is used at the present time, sir.

16 MR. MACLEOD: Coming back to your preli-  
17 minary remarks, you suggested that the idea of a  
18 professional or pure pharmacy would not be practical.  
19 You, I think, suggested that the people had evidenced  
20 no desire for such an institution. Is it not a fact  
21 under the present pricing policies, it does not matter  
22 where the customer goes, he is going to be charged  
23 very much the same price?  
24

25 MR. RICHARDSON: Not necessarily so in  
26 Manitoba at the present time.

27 MR. MACLEOD: Will you agree with me  
28 on this: that the customer has been given no real  
29 opportunity. It has not been placed before him he  
30 can go to some large place and make a saving. Is



1 that true? He has not been faced with a clear-cut  
2 choice of going to the corner pharmacy and paying  
3 \$2 or going downtown to John Jones' Pure Pharmacy  
4 and paying \$1.50.

5  
6 MR. RICHARDSON: In certain instances  
7 where the physician may know that a certain store  
8 is 25 cents or 50 cents less than another, that  
9 physician may suggest that to the patient.

10 MR. MACLEOD: Yes, and would you have  
11 any way of knowing or can you express any opinion  
12 on the number of those knowledgeable customers who  
13 would take advantage of this opportunity?

14 MR. RICHARDSON: No sir.

15 MR. MACLEOD: So that when you say  
16 that the people don't want it, I suggest to you that  
17 the people have never had a chance to exercise this  
18 choice? There has never been a real choice put to  
19 them?

20  
21 MR. RICHARDSON: My comment, sir, on  
22 that idea of people not wanting it, is my observa-  
23 tion in my own store where they have asked and are  
24 expecting a lot of minor services that the pharma-  
25 cist would do for the customer.

26 If a customer is only interested in  
27 the prescription, then it is possible that he may  
28 want this centre dispensing outlet.

29 MR. MACLEOD: Yes?

30 MR. RICHARDSON: But if he wants the



1 services that the pharmacist supplies at the corner  
2 pharmacy, that is my thought that it is not feasible  
3 at the moment.

4 MR. MACLEOD: I am not suggesting that  
5 this would work or it would not work. What I am  
6 trying to bring out is: there has been no real test  
7 of it? There has been no place where the consumer  
8 knew he could take his prescription and have it filled  
9 at a lower price than he could in his neighbourhood  
10 pharmacy?

11 MR. RICHARDSON: To my knowledge there  
12 has been no overall advertising to the public, if  
13 you want to call it advertising, or to all physicians  
14 that any one dispensary will dispense at a lower  
15 price than any other store.

16 THE CHAIRMAN: To put the question a  
17 little differently. Do you know of any pharmacy in  
18 Greater Winnipeg which, as a practice, charges less  
19 than what we regard as the normal price for prescrip-  
20 tions and is known in fact to carry on that practice?

21 MR. RICHARDSON: Yes, I know of two or  
22 three outlets that have and use a different pricing  
23 schedule than I do.

24 THE CHAIRMAN: A somewhat lower pricing  
25 schedule?

26 MR. RICHARDSON: To use the word  
27 "lower", I don't know, sir.

28 THE CHAIRMAN: Well then ---  
29  
30





1  
2 MR. RICHARDSON: Their methods will  
3 often produce a higher price on a less expensive  
4 item and a lower price on an expensive item so that  
5 his average dispensing price, I don't know.

6 MR. MACLEOD: I don't want to bring  
7 out different names of any particular stores here.  
8 I was wondering if I may show this article to Mr.  
9 Richardson and ask him if the firm name in that  
10 article is the principal one to which he has referred.

11 MR. RICHARDSON: That is the one, yes.

12 MR. MACLEOD: I don't think perhaps I  
13 should identify the book for the record either.

14 THE CHAIRMAN: Is it one of these or  
15 both of them?

16 MR. MACLEOD: I beg your pardon, sir?

17 THE CHAIRMAN: Is it one of these or  
18 both of them?

19 MR. MACLEOD: Are you familiar with  
20 this publication, the Price Book on Drugstore Merchan-  
21 dise, published by the Canadian Pharmaceutical Journal?

22 MR. RICHARDSON: Yes.

23 MR. MACLEOD: Do you use that in your  
24 store?

25 MR. RICHARDSON: Yes, quite a lot, sir.

26 MR. MACLEOD: Do you know if that is  
27 generally used by druggists?

28 MR. RICHARDSON: It is used quite a lot.  
29 I don't know by what proportion, sir.  
30



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1 MR. MACLEOD: Do you normally adhere  
2 to the suggested list price as listed in this book?

3 MR. RICHARDSON: Generally.

4 MR. MACLEOD: Perhaps you could be a  
5 little more specific about that and tell us when you  
6 do not?

7 MR. RICHARDSON: This book is published  
8 twice a year. It is not necessarily always up to  
9 date. If it is up to date I would be more interested  
10 in using that price on any particular item.

11 MR. MACLEOD: Do you find it is a con-  
12 venience to you in your store?

13 MR. RICHARDSON: Yes, I use it quite a  
14 lot, sir.

15 -

16 -

17 -

18 -



dpw

1 MR. MACLEOD: Do you use the drug index  
2 published by Drug Merchandising?

3 MR. RICHARDSON: Yes sir.

4 MR. MACLEOD: And do you use this,  
5 are you familiar with this relatively new book, by  
6 Hughes, Compendium of Pharmaceutical Specialties?

7 MR. RICHARDSON: Yes, I have that in  
8 the store.

9 MR. MACLEOD: Does that book list  
10 most of the drug products available in Canada today?

11 MR. RICHARDSON: At the time of publi-  
12 cation, yes.

13 MR. MACLEOD: And there is at least  
14 one addendum?

15 MR. RICHARDSON: Yes.

16 MR. MACLEOD: But this book, with the  
17 most recent addendums, would list most of the pharma-  
18 ceutical products available in Canada today?

19 MR. RICHARDSON: Yes.

20 THE CHAIRMAN: Does that contain  
21 prices, or is it simply a list?

22 MR. MACLEOD: No, it does not contain  
23 prices. It simply lists products under trade names.  
24 There is first of all a description, then the indica-  
25 tions, administration and house of supply.

26 MR. MACLEOD: How are the purchases in  
27 respect of your store divided, as between direct  
28 purchases from manufacturers and purchases through  
29  
30



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1 wholesalers?

2  
3 MR. RICHARDSON: I haven't a figure on  
4 that sir.

5 MR. MACLEOD: Could you give me any  
6 estimate at all?

7 MR. RICHARDSON: No, at the moment I  
8 don't think that I could.

9 MR. MACLEOD: Are there some firms,  
10 such as Eli Lilly, and some others, that encourage  
11 you to buy through the wholesaler, and normally  
12 refuse to sell you directly?

13 MR. RICHARDSON: Eli Lilly do encourage  
14 to buy through the local wholesaler, yes. I don't  
15 know about their refusal to sell direct.

16 MR. MACLEOD: In any event, they prefer  
17 you to buy through the wholesaler. Are any firms,  
18 I am just picking them out of the hat, such as Ayerst,  
19 who maintain local depots, and rather encourage you  
20 to buy directly?

21 MR. RICHARDSON: No, they don't care  
22 where you buy.

23 MR. MACLEOD: Has the particular firm  
24 that I mentioned, Ayerst, do you know if it has a  
25 branch depot in Winnipeg?

26 MR. RICHARDSON: Yes it has.

27 MR. MACLEOD: You can buy the products  
28 directly from the branch depot?

29 MR. RICHARDSON: Yes.  
30



1 THE CHAIRMAN: Is there any difference  
2 in price when you buy from the depot rather than the  
3 wholesaler?  
4

5 MR. RICHARDSON: In some products from  
6 this particular firm, yes.

7 THE CHAIRMAN: That would tend to indi-  
8 cate that is where they would like you to buy,  
9 because that is where you probably would buy, where  
10 you get a lower price?

11 MR. RICHARDSON: Yes.

12 MR. MACLEOD: Do you normally get a  
13 better price when you buy directly from the manufac-  
14 turer than from the wholesaler?

15 MR. RICHARDSON: Possibly there are,  
16 speaking on prescription items or drug items for  
17 dispensary use there are more firms from which we  
18 can buy direct with a little better price than through  
19 the jobber.

20 MR. MACLEOD: What would be a typical  
21 discount from the manufacturer, 40%?  
22

23 MR. RICHARDSON: Yes.

24 MR. MACLEOD: Isn't that almost stan-  
25 dard?

26 MR. RICHARDSON: Pretty well.

27 MR. MACLEOD: From a wholesaler, what  
28 would the discount be, what would the range be?

29 MR. RICHARDSON: It varies with what  
30 the manufacturer gives to the wholesaler, and that





1 varies as much as, well, I couldn't answer as a  
2 wholesaler here, but I understand from 10 to 15%  
3 variation from various companies.  
4

5 MR. MACLEOD: What discount would you  
6 receive from the wholesaler?

7 MR. RICHARDSON: On a number of  
8 products we would receive 33%.

9 MR. MACLEOD: Would 40% from a whole-  
10 saler be an exceptional discount?

11 MR. RICHARDSON: No, it is not excep-  
12 tional.

13 MR. MACLEOD: You would sometimes  
14 receive that?

15 MR. RICHARDSON: Yes.

16 MR. MACLEOD: Would your discount  
17 sometimes be below 33?

18 MR. RICHARDSON: It could be, yes.

19 MR. MACLEOD: But would it be excep-  
20 tional for it to be below 33?

21 MR. RICHARDSON: There are not many  
22 from the larger drug houses that would give less  
23 than that.  
24

25 MR. MACLEOD: How do these discounts  
26 that you have told us about in respect of dispensary  
27 items compare with discounts you receive on sundry  
28 drug merchandise, patent medicines and the like?

29 MR. RICHARDSON: Unless you were  
30 buying these patents in quantities, or so-called



1 deals, they would be approximately the same

2 MR. MACLEOD: Are there small manufac-  
3 turers, particularly those trying to break into the  
4 field, and I am speaking now of dispensary items,  
5 who offer you larger discounts than 40% sometimes  
6 offer you up to 50 or even 60%?

7 MR. RICHARDSON: No, I would say that  
8 the smaller outfits are not offering more to my  
9 knowledge. I don't know whether you have any parti-  
10 cular one in mind sir?

11 MR. MACLEOD: No, I am just asking the  
12 question generally.

13 MR. RICHARDSON: No, generally the  
14 discount is not greater.

15 MR. MACLEOD: Is not greater than the  
16 larger companies?

17 MR. RICHARDSON: Yes.

18 MR. MACLEOD: You spoke of deals.  
19 They are quite common in the patent medicine and  
20 sundry drug field, are they?

21 MR. RICHARDSON: In season, yes, there  
22 are a good number of them.

23 MR. MACLEOD: What do you mean by in  
24 season, cough medicine in the winter and so on?

25 MR. RICHARDSON: Yes, a Fall deal, or  
26 summer or winter deal, depending on what the parti-  
27 cular product was.

28 MR. MACLEOD: It is not the practice  
29  
30



1 of druggists, is it, when you get a good deal on  
2 some particular product to put a sale on on that  
3 product?

4 MR. RICHARDSON: Not necessarily sir,  
5 no sir.

6 MR. MACLEOD: Do you sometimes do  
7 that?

8 MR. RICHARDSON: It has been done,  
9 yes.

10 MR. MACLEOD: When was the last time  
11 that you did it?

12 MR. RICHARDSON: Some time ago sir.  
13 Generally my thought is this. I am buying a quan-  
14 tity of goods at a price, or on a deal, and my  
15 thought is that it is an investment. I am investing  
16 my money in that quantity of goods with the thought  
17 of on sale this month or in three months' time, that  
18 I will have realised another 2% or 5%, or whatever  
19 it might be. It is considered an investment more  
20 than a present-day sale.

21 THE CHAIRMAN: That would mean, I  
22 suppose, that you do not buy a quantity under  
23 those circumstances with the idea of cutting your  
24 price and selling it quickly, but that you buy the  
25 quantity so that you have a stock for a certain  
26 period of time, maybe a longer period of time than  
27 if you hadn't been able to get that deal, but  
28 during that period of time you will sell at your  
29  
30



1 regular price and with the larger gross profit the  
2 net will be the same as in the ordinary way?

3 MR. RICHARDSON: Yes sir.

4 MR. MACLEOD: Do you find that after  
5 a heavy promotional campaign directed at doctors  
6 has been launched, that you find an increasing  
7 number of prescriptions being written for the drug  
8 which has been promoted?  
9

10 MR. RICHARDSON: Sometimes, yes sir.

11 MR. MACLEOD: In other words, do you  
12 find that when the detail men move into Winnipeg  
13 with a heavy campaign for a new product, do you  
14 find it reflected in your sales?

15 MR. RICHARDSON: Quite often.

16 MR. MACLEOD: Do you find that fashions  
17 change in medicine, the doctors are prescribing a  
18 certain drug today and that drops out of the picture  
19 and is replaced by something else?  
20

21 MR. RICHARDSON: Yes sir.

22 MR. MACLEOD: As far as the druggist  
23 is concerned, does that raise a problem of stocking  
24 and obsolete stock that cannot be sold?

25 MR. RICHARDSON: Yes, particularly in  
26 a metropolitan area where the number of physicians  
27 is great. In a small area, a country town, there  
28 may be one or two physicians and to some extent I  
29 understand that the pharmacists are in a position  
30 and will co-operate. The physician will indicate to



1 the pharmacist that he wants to use a product, and  
2 the pharmacist will stock accordingly.

3 THE CHAIRMAN: Has the retail druggist  
4 any right to return goods and receive credit for  
5 them from the manufacturer, or the wholesaler?

6 MR. RICHARDSON: Some manufacturers  
7 will or do have what they call automatic shipments.  
8 They will produce a new product and if you have  
9 signed on for this automatic shipment, you will  
10 receive a token shipment of this new product as it  
11 is released, and you have the privilege of returning,  
12 in whatever period they say, it might be six months,  
13 what you have not used may be returned. Other than  
14 that, some manufacturers within a certain period,  
15 sometimes this period is taken from the date on the  
16 package, the lot number, will assume and give the  
17 pharmacist credit on return of an unopened package,  
18 if the label etc. is in good shape.

19 THE CHAIRMAN: These automatic ship-  
20 ments that you said were token shipments, those are  
21 pretty small shipments?

22 MR. RICHARDSON: It would be possibly  
23 the small normal size of the packing by the manufac-  
24 turer. If he packed in twelves and hundreds, he  
25 would possibly send a bottle of 12.

26 THE CHAIRMAN: And apart from that,  
27 the right to return is rather unusual?

28 MR. RICHARDSON: Yes.  
29  
30





1 MR. MACLEOD: Is that a serious expense  
2 to you in business, having drugs that you purchased  
3 ready to fill prescriptions no longer being called  
4 for?

5 MR. RICHARDSON: Yes sir, we invariably  
6 end up with a few tablets or capsules in a bottle, or  
7 a few ounces of liquid which is never dispensed or  
8 used.

9 MR. MACLEOD: There is another point  
10 arising out of that.

11 MR. WHITELEY: Have you any figure of  
12 what your write-off of that nature is each year?

13 MR. RICHARDSON: No I haven't.

14 THE CHAIRMAN: Can you say whether it  
15 would be a substantial item in your cost figure?

16 MR. RICHARDSON: As far as possible,  
17 in my own operation sir I have kept it as close as  
18 I can.

19 THE CHAIRMAN: That is natural.

20 MR. RICHARDSON: I have discontinued  
21 acceptance of these automatic shipments, even  
22 though they have a return privilege. I have found  
23 that we might slip up and not return it or something,  
24 so I have gradually eliminated acceptance of these.

25 THE CHAIRMAN: Is it your experience  
26 that it is or is not a substantial loss item which  
27 would affect your cost structure noticeably? Is it  
28 or is it not a substantial item? Are you able to



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1 say? Does it amount to much?

2 MR. RICHARDSON: A rough figure of what  
3 I set aside last year as considering not being saleable  
4 or not being called for, would be \$100.00 to \$150.00.

5 THE CHAIRMAN: That would be a fairly  
6 small percentage?

7 MR. RICHARDSON: Possibly not too large  
8 if you figure we have \$5,000.00 profit.

9 THE CHAIRMAN: \$100.00 to \$150.00 is  
10 not based on stock. It is based on your total sales  
11 as far as it being a cost factor of importance or  
12 little importance it has to be related to your sales  
13 for the year. If it is \$100.00 to \$150.00 in one  
14 year, well it is a loss shall we say of \$100.00 to  
15 \$150.00. That isn't a serious factor in your busi-  
16 ness it would seem to me.  
17  
18  
19  
20  
21  
22  
23  
24  
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26  
27  
28  
29  
30



1 MR. RICHARDSON: If we can keep it  
2 down to that figure.

3 THE CHAIRMAN: Yes. Oh, yes, of  
4 course, that is it.

5 MR. MACLEOD: Do new products, new  
6 drug developments cause a problem to you? Do you  
7 feel you have to stock new drug products as they  
8 are put on the market? I am thinking particularly  
9 of the class of new pharmaceuticals such as are  
10 listed in the Canadian Pharmaceutical Journal there.

11 MR. RICHARDSON: I try to consider  
12 when detailed on these products what the product is,  
13 who the manufacturer is and try to take into consi-  
14 deration by guessing what I think physicians in my  
15 area might use. Oftentimes I do not order until I  
16 receive my first prescription.

17 THE CHAIRMAN: Do you look into a  
18 crystal ball or something?

19 MR. RICHARDSON: As I say, sir, it is  
20 a guess.

21 MR. MACLEOD: Are you able to get  
22 emergency supplies from the wholesaler if you need  
23 them?

24 MR. RICHARDSON: Yes, sir.

25 MR. MACLEOD: And I presume that is  
26 of great assistance to you, is it, to have a whole-  
27 saler available in the city that you can turn to?

28 MR. RICHARDSON: Yes, sir.



1 MR. MACLEOD: Now, the opinion has  
2 been expressed at various times that sometimes when  
3 the main drug itself falls into disuse or relative  
4 disuse combinations of it will be continued to be  
5 used for years. As I understand it, aureomycin and  
6 teramycin are being displaced to a certain extent by  
7 tetracycline, but drops or ointments or lotions and  
8 those types will be widely sold. First of all, is  
9 my premise in that question correct, that aureomycin  
10 and teramycin are being displaced by tetracycline?

12 MR. RICHARDSON: Yes, that is correct.

13 MR. MACLEOD: What about the subsi-  
14 diary products?

15 MR. RICHARDSON: They also go by the  
16 board.

17 MR. MACLEOD: Do they have a tendency  
18 to have a longer life than the main product itself?  
19 Say, for example, 250-milligramme capsules as compared  
20 to, say, eye-drops?

21 MR. RICHARDSON: No.

22 MR. MACLEOD: You would say they would  
23 be the same?

24 MR. RICHARDSON: In some instances  
25 shorter.

26 THE CHAIRMAN: You mean there is no  
27 pattern?

28 MR. RICHARDSON: Not for the one  
29 chemical, no.  
30



1 MR. MACLEOD: When the detail men are  
2 promoting prescription drugs, what approach do they  
3 take? I mean, you would have no choice of whether  
4 a prescription drug is sold or not; that would be  
5 entirely up to the doctor.  
6

7 MR. RICHARDSON: Yes.

8 MR. MACLEOD: Do the detail men come  
9 around and endeavour to get you to stock these  
10 drugs?

11 MR. RICHARDSON: Possibly I am a  
12 little bit stubborn, sir, but some of the detail  
13 men realise that now, and if I tell them the story  
14 they accept it.

15 MR. MACLEOD: What is the basis of  
16 their approach? Do they put this across to the  
17 doctor that there will soon be a demand in pres-  
18 criptions?

19 MR. RICHARDSON: Yes, in some cases,  
20 and in others they are just passing on information  
21 and that possibly it will be a hospital item or  
22 they don't expect it to be used right away, or will  
23 be used by certain class of physicians only, and  
24 they try to give us that information.  
25

26 MR. MACLEOD: That is about all the  
27 information they can give you. You yourself have  
28 no control over the sale.

29 MR. RICHARDSON: No, sir. If they  
30 have been to the physician first they sometimes





1 tell us what reception they have had from the physi-  
2 cian that they think we might be dealing with, but  
3 if not they tell us the story.

4 THE CHAIRMAN: I think you said a  
5 moment ago it is not your practice to any extent  
6 to buy new drugs purely on speculation?  
7

8 MR. RICHARDSON: I don't rush into  
9 it, sir.

10 THE CHAIRMAN: Do you wait until you  
11 get some request?

12 MR. RICHARDSON: Quite often, quite  
13 often.

14 MR. MACLEOD: I think I covered this  
15 with you before, but I just want to make sure. Are  
16 you able as a practising pharmacist to gauge the  
17 effect of promotional campaigns that are directed  
18 towards doctors? Do you see in your business,  
19 company "X" launching a massive campaign for a  
20 particular product - do you see that reflected in  
21 your business?  
22

23 MR. RICHARDSON: Sometimes we do, yes.

24 MR. MACLEOD: Is it the pattern that  
25 it will be or is it the exception?

26 MR. RICHARDSON: It depends on the  
27 product, sir.

28 MR. MACLEOD: Would you give us an  
29 illustration of that to perhaps make it clear to  
30 us how it works?



1 MR. RICHARDSON: The diuretic chloro-  
2 thiazide has had quite a run; the tranquilizers  
3 have to some extent come in place of phenobarb.,  
4 certain hypertension medications have come in place  
5 of phenobarb.  
6

7 MR. MACLEOD: I was wondering if you  
8 could express any opinion of the result of a drug  
9 company launching a massive campaign to promote "X"  
10 drug to doctors. Is such a campaign usually reflec-  
11 ted in an increased sale of that drug?

12 MR. RICHARDSON: Yes, for a period at  
13 least.

14 MR. MACLEOD: In other words, these  
15 promotional campaigns that the drug manufacturers  
16 launch frequently work?

17 MR. RICHARDSON: Yes.

18 MR. MACLEOD: Would you say that they  
19 usually work?

20 MR. RICHARDSON: I would say often.  
21 I don't know that I would say usual.

22 MR. WHITELEY: How are you informed  
23 as to the scale of the manufacturer's promotional  
24 campaign?  
25

26 MR. RICHARDSON: We don't know ahead  
27 of time. They may tell us they are going to do a  
28 certain thing. But if they are pursuing that  
29 campaign the detail man may be back in to see us in  
30 two weeks or a month and state that they are



1 continuing with the campaign on that particular pro-  
2 duct for a period of a month or two months or what-  
3 ever they decide on.

4 THE CHAIRMAN: They tell you what they  
5 are doing?

6 MR. RICHARDSON: They try to give us  
7 some indication of what they are detailing the  
8 physician on.

9 THE CHAIRMAN: Do they commonly leave  
10 literature with you such as they use in the campaign?

11 MR. RICHARDSON: Often they do, sir.

12 THE CHAIRMAN: But you have some evi-  
13 dence you think reliable as to what is going on in  
14 the campaign.

15 MR. RICHARDSON: No real concrete  
16 evidence, no, sir, other than what the detail man  
17 tells me, the literature we receive from him in the  
18 mail or the advertising we might see in the trade  
19 journal.

20 THE CHAIRMAN: In your opinion does  
21 that give you a fairly good understanding of what  
22 is going on? Not detailed accuracy but a fairly  
23 good understanding, whether it is what may be called  
24 a massive campaign or something of a lesser intensity?

25 MR. RICHARDSON: Not necessarily.

26 THE CHAIRMAN: You are really guessing  
27 on whether it is a massive campaign?

28 MR. RICHARDSON: Yes.



1 MR. MACLEOD: To your knowledge were  
2 campaigns conducted with some of the penicillins,  
3 such as syncillin and - what is the other one?  
4

5 MR. RICHARDSON: Those two products  
6 to my knowledge were not heavily campaigned. It  
7 is possible that they did a certain amount or a  
8 fair amount of this campaigning directed to hospi-  
9 tals where they might see the results more quickly.  
10 Sometimes these products - I don't know in this  
11 particular case, but some products are available  
12 for intravenous use before they are available for  
13 oral use, and sometimes they are used in a hospital  
14 rather than through a retail pharmacy.

15 MR. MACLEOD: Just another point.  
16 Are there differences between the products which a  
17 drugstore would be required to stock because of its  
18 dealing with walking patients, and so on, and the  
19 products which a hospital would require to stock?  
20 Do your prescription products range over different  
21 areas?  
22

23 MR. RICHARDSON: I mentioned intra-  
24 venous products. The retail pharmacist is not  
25 required to stock normally a great deal of intra-  
26 venous products.

27 MR. MACLEOD: There would be a very  
28 small demand for those products?

29 MR. RICHARDSON: Yes.

30 MR. MACLEOD: But they would be widely



1 used in the hospital?

2 MR. RICHARDSON: I have no figures, but  
3 they would be more so than in the retail pharmacy.

4 MR. MACLEOD: And I presume there  
5 would be instances where a product would be widely  
6 used in a hospital but not sold in a pharmacy?

7 MR. RICHARDSON: Yes.

8 MR. MACLEOD: And I presume the  
9 reverse situation would apply?

10 MR. RICHARDSON: I don't know about  
11 the reverse.

12 MR. MACLEOD: Can you express any  
13 opinion as to whether proprietary and patent medi-  
14 cine sales have been increasing in recent years or  
15 decreasing?

16 MR. RICHARDSON: I could only express  
17 a personal thought, sir. Over the last three-year  
18 period in my own business, where my volume of busi-  
19 ness has increased, and, as I mentioned, there has  
20 been a slight decline in percentage of descriptions  
21 dispensed, and the fact that I have no demand on  
22 any large sundry item, and assuming that I am selling  
23 myself more patent medications. This might be a  
24 local trend in my own area.

25 MR. MACLEOD: Those are all the ques-  
26 tions I have sir.

27 MR. GREGORY: Mr. Chairman, if I may  
28 just put two questions to Mr. Richardson for the  
29  
30





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Richardson

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sake of the record.

Mr. Richardson, you answered a number of questions with relation to operations in your own place of business. Would you tell the Commission how you would describe the location of your business. Would you call it suburban or on the outskirts of the metropolitan area?

1

10

10

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/dpw

1 MR. RICHARDSON: Yes, I have a suburban  
2 pharmacy. I am on the outskirts. I am situated on  
3 Henderson Highway, Provincial Highway No. 9. I am  
4 the furthest store north on that highway. The next  
5 store north of me would be in Selkirk. South of me  
6 there is a store within half a mile.

8 MR. GREGORY: Is it possible then ---

9 THE CHAIRMAN: Which municipality is  
10 that?

11 MR. RICHARDSON: I am situated in  
12 North Kildonan.

13 MR. GREGORY: Is it possible, Mr.  
14 Richardson, that the proprietor of a store in a  
15 central residential area or an area largely occupied  
16 by apartment houses or in the downtown business area  
17 would give different answers to some of the questions  
18 you were asked about your dispensary? Would there  
19 be a significant difference in the answer?  
20

21 MR. RICHARDSON: I would think that a  
22 pharmacy in central downtown Winnipeg, having a  
23 greater transient trade or office trade, would not  
24 have the same family trade that I might have. Their  
25 prescription business possibly would vary. They  
26 might have more on sundry items than I carry.

27 THE CHAIRMAN: I suppose what your  
28 answer means is that in your situation a personal  
29 element and personal relationship to the customers  
30 is likely to have more influence than in a metropolitan



1 downtown store?

2  
3 MR. RICHARDSON: I think so, sir. I  
4 think the customer will come back to me whereas in  
5 a downtown store a certain number of customers defi-  
6 nitely would go back to that store but there would  
7 also be quite a number of customers or potential  
8 customers walking down the street who decided they  
9 needed something, go in and purchase it, and they  
10 may not go back to that store as a routine.

11 THE CHAIRMAN: That is, a downtown  
12 store would have more casual customers than you  
13 would have?

14 MR. RICHARDSON: I would think so.

15 MR. GREGORY: Just one other question  
16 for clarification, if I may, Mr. Chairman.

17 THE CHAIRMAN: Yes.

18 MR. GREGORY: Would you say - if you  
19 have had experience in this respect say so - that  
20 the pharmacy or dispensary operation downtown would  
21 be significantly different from yours? What I am  
22 getting at is: if the Board in the course of this  
23 inquiry called before them a downtown type pharma-  
24 cist, do you consider that would be advisable?

25  
26 MR. RICHARDSON: If you were thinking  
27 of a retail pharmacy as against a clinic pharmacy,  
28 yes. Their answers could possibly be different than  
29 mine.

30 MR. GREGORY: Those are the only



1 questions I have, Mr. Chairman. I wanted to see if  
2 I could get from this man the fact that location  
3 does have something to do with it.

4 MR. CARIGNAN: Mr. Richardson, you  
5 said previously, if I understood you correctly, that  
6 you know of two or three drugstores who were selling  
7 at a lower than normal price, at least on certain  
8 items, and the name of one of those drugstores was  
9 shown to you and to us by Mr. MacLeod. My question  
10 is the following: was there any complaint made to  
11 the Association about the advertising policies or  
12 about the selling policies of these drugstores or  
13 any of them?

14 MR. RICHARDSON: To my knowledge, this  
15 particular store made no approach to the Association  
16 with regard to their policy.

17 MR. CARIGNAN: Was there any complaint  
18 from any pharmacist made to the Association about  
19 the advertising or selling policies of this particu-  
20 lar drugstore?

21 MR. RICHARDSON: Yes, that could be.

22 THE CHAIRMAN: You mean that did  
23 happen? There is a difference between "it could be"  
24 and "it could happen".

25 MR. RICHARDSON: Yes sir. I don't  
26 know of any written complaint; verbal complaints,  
27 yes.

28 MR. CARIGNAN: Were these policies  
29  
30



1 found unethical by the Association? Did the Associa-  
2 tion do something about it?

3 MR. RICHARDSON: In this particular  
4 case, the Association tried to approach the pharma-  
5 cist operating this pharmacy with the idea of trying  
6 to find out his thoughts or his ideas on the matter;  
7 with the idea being to try to find out whether he  
8 actually thought that his method of pricing would be  
9 an answer to all the pharmacists of Manitoba. We  
10 did not reach him.

11 THE CHAIRMAN: You did not talk to him  
12 more --

13 MR. RICHARDSON: He would not meet us.

14 THE CHAIRMAN: He would not meet you at  
15 all?

16 MR. RICHARDSON: No sir.

17 THE CHAIRMAN: So there was no discussion?

18 MR. ANDERSON: No discussion.

19 MR. CARIGNAN: He was not asked to  
20 change his policies.

21 MR. RICHARDSON: No, not specifically  
22 asked to change, no.

23 MR. WHITELEY: I have a few questions  
24 on the brief and the annex. I wonder which of these  
25 gentlemen will be in the best position to answer  
26 them.

27 MR. GREGORY: The brief and the which,  
28 sir?





1 MR. WHITELEY: And Annex 3.

2 MR. GREGORY: I have forgotten which  
3 3 is.

4 MR. WHITELEY: The report of the  
5 Drug Committee.

6 MR. GREGORY: You have two gentlemen  
7 here who were on the Joint Committee at least -  
8 three, I beg your pardon.

9 MR. WHITELEY: My first question in  
10 relation to the brief of the Association; on page  
11 9 the paragraph commencing on that page this sentence  
12 appears: "It has been the experience of the retail  
13 pharmacists in Manitoba that the discount allowed  
14 on the drug item which may be sold without prescrip-  
15 tion but which may only be sold in a retail pharmacy  
16 is sufficient to meet the costs of sales and some  
17 profit, if the sale is made by a sales clerk who is  
18 not a pharmacist".

19 I was wondering if any of the gentle-  
20 men present could expand on that sentence.

21 MR. HOLLAND: Might I answer that  
22 question, Mr. Chairman?

23 THE CHAIRMAN: Yes.

24 MR. HOLLAND: I think what we had  
25 in mind there was certain products that can be sold  
26 by a non-pharmacist in the front of the store, that  
27 is, outside of the dispensary. They did not require  
28 supervision by a pharmacist and therefore no charge  
29  
30



1 necessary - no additional charge to the sale whereas  
2 on a product which must be dispensed by a pharmacist,  
3 which requires the services of a pharmacist, and  
4 that is where the additional fee is put on. That  
5 is why it is justified.

6  
7 In other words, we tried to have the  
8 pharmacist paid through the returns on their pres-  
9 criptions and so that they are not necessarily  
10 being - non-prescription items are not necessarily  
11 subject to that additional fee. Does that answer  
12 the question?

13 MR. WHITELEY: I am not clear just  
14 what products you are putting in this group.

15 MR. HOLLAND: There are certain pro-  
16 ducts which do not require prescription made by a  
17 number of the pharmaceutical houses. I could  
18 mention certain vitamin products, Vitamin B Complex.  
19 In the case of so-called therapeutical vitamins,  
20 they should be sold only by a pharmacist. In the  
21 case of codeine-containing products, they can be  
22 sold by the clerk as long as the pharmacist is  
23 supervising the sale and in our particular case we  
24 initial all codeine-containing products. It is  
25 not compulsory but we do it as a protection to the  
26 public.

27  
28 That is because we want to know to  
29 whom those products are going to be given in view  
30 of the fact it is unlawful to administer codeine



1 preparations to children under two years old.

2 That is only one example where a phar-  
3 macist can enter into drugstore operations where it  
4 is not necessarily compulsory.  
5

6 MR. WHITELEY: Are you trying to make  
7 some distinction between the actual person who makes  
8 the sale or the type of product?

9 MR. HOLLAND: Well, the type of  
10 product determines who can make the sale or super-  
11 vise it.

12 MR. WHITELEY: If there was no clerk  
13 in the store and the pharmacist made the sale --

14 MR. HOLLAND: Yes. In that case the  
15 usual discount, of course, would be the list price  
16 of what that product is sold at in any case. There  
17 is no additional charge put on to non-prescription  
18 items.

19 MR. WHITELEY: Would you consider in  
20 that case the pharmacist is not being adequately  
21 rewarded?  
22

23 MR. HOLLAND: I didn't get that, sir.

24 MR. WHITELEY: Is it considered in  
25 that case that the pharmacist is not being adequately  
26 rewarded?

27 MR. HOLLAND: No, I don't think they  
28 gave any --

29 MR. WHITELEY: You see the sentence  
30 ends: "If the sale is made by a sales clerk who is



1 not a pharmacist". In other words, it is suggested  
2 if the sale was made by a pharmacist the situation  
3 would be different.  
4

5 MR. HOLLAND: No. These are products  
6 which may be sold by a sales clerk and it is not  
7 necessary for a pharmacist to either make the sale  
8 or supervise it.

9 MR. WHITELEY: I understand that but  
10 the question is: what is the situation if the pharma-  
11 cist actually makes the sale?

12 MR. HOLLAND: It is just the same  
13 situation. The customer pays exactly the same price.

14 They may get some additional advice or  
15 information from the pharmacist regarding the product  
16 that they might not expect to get from the sales  
17 clerk. There is an advantage to the customer in  
18 this.

19 MR. WHITELEY: Yes, but the sentence  
20 suggests in that case the price is not sufficient.

21 MR. HOLLAND: Well, I don't think that.  
22 I think that is drawing rather a fine line between --  
23 This is just that products which require prescrip-  
24 tion or products which are sent out on prescription  
25 are handled by the pharmacist. For that reason a  
26 fee is usually added to the prescription.  
27

28 THE CHAIRMAN: I think, Mr. Holland,  
29 that the question at issue is a fairly narrow one.  
30 Dealing with the products described in this sentence



1 it says: "The price is sufficient to meet the cost  
2 of sales and some profit if the sale is made by a  
3 clerk who is not a pharmacist".

4 If the sale is made by somebody who  
5 is a pharmacist, what seems to be meant by this is  
6 that that is a higher-priced salesman and as a  
7 result of that the price does not give a sufficient  
8 return to cover the costs plus a small profit.

9  
10 MR. HOLLAND: I don't believe that  
11 was the intention of the group, Mr. Chairman.

12 MR. RICHARDSON: Sir, if I may comment.  
13 I think what we were trying to show here was the  
14 fact that there are several classes of items and  
15 that the various classes - some of these various  
16 classes require certain further supervision than  
17 actual selling.

18 THE CHAIRMAN: I think that is fully  
19 understood. It is just that the language of this  
20 sentence does seem to suggest you can only get by  
21 and make a little profit if the salesman in this  
22 particular type of thing is a lower-paid salesman.  
23 He is not a pharmacist. He doesn't get the same  
24 type of salary. If a pharmacist is doing it on  
25 the level of remuneration he has to receive, it is  
26 not a profitable business. That is the inference  
27 that seems to come from this sentence.

28  
29 MR. GREGORY: The sentence may not  
30 be clear, Mr. Chairman, because it may not have





1 been written by a pharmacist.

2 THE CHAIRMAN: Well, it is supported  
3 by the pharmacists. It is a brief of the Associa-  
4 tion. Perhaps that is all the information we can  
5 get about it.  
6

7 MR. WHITELEY: I was going to ask  
8 whether a pharmacist in a drugstore does not  
9 actually sell products on which no great margin is  
10 received?

11 MR. HOLLAND: A pharmacist may sell  
12 these products in the front store, wrap the package  
13 up and give it to a customer, and there is no extra  
14 work such as checking quantity, prescription, label-  
15 ling, or recording involved, and all the other  
16 services that must go with a prescription, but a  
17 pharmacist could sell these other products in the  
18 front store, and 40% would be sufficient. It would  
19 just be a question of wrapping the parcel and delive-  
20 ring it to the customer.

21 MR. WHITELEY: But I had in mind that  
22 a pharmacist might also sell drug items on which no  
23 greater margin would be received.

24 MR. HOLLAND: He would not have the  
25 extra work of making up a prescription.

26 MR. WHITELEY: But I mean there is  
27 time involved in the sale.  
28

29 THE CHAIRMAN: A relatively high-  
30 priced pharmacist doing the selling of non-drug



1 items, or items that do not require a prescription,  
2 which may be done by a lower-priced salesman, the  
3 cost of those items is higher.

4 MR. HOLLAND: A pharmacist must be on  
5 duty at all times, and if he was busy making up a  
6 prescription he would not be in the front of the  
7 store selling.

8 THE CHAIRMAN: Yes, but if a proprietor  
9 of the store has one or more other pharmacists paid  
10 by him, he pays them a higher rate of salary than to  
11 an ordinary sales clerk, and if a great part of their  
12 time is in selling items which do not require a  
13 pharmacist, the cost of those items would be higher.

14 MR. HOLLAND: That is one way of  
15 looking at it, but if the pharmacist, who must be on  
16 duty at all times, is at least selling something in  
17 the meantime, he is of more value to the owner than  
18 just waiting for a prescription to come in.

19 THE CHAIRMAN: I think the real ques-  
20 tion is what is the meaning of the sentence.

21 MR. WHITELEY: In Annex No. 3, at  
22 page 26, the report of the Joint Committee, it is  
23 two-thirds of the way down the page, it states: "It  
24 should be noted that many pharmacies in Manitoba  
25 have two or even three manager or owner pharmacists  
26 who are active in the operations of their individual  
27 pharmacies". I was wondering whether stores opera-  
28 ting on the scale of the stores which were surveyed  
29  
30



1 require more than a single manager?

2 MR. HOLLAND: I think, Mr. Chairman,  
3 where there are a number of pharmacists employed,  
4 it is an indication that there are more prescrip-  
5 tions being filled. It is possibly a bigger opera-  
6 tion, and it may be that their hours are considerably  
7 longer than in some of the smaller operations, where  
8 the pharmacist is self-employed and working shorter  
9 hours per day.

10 MR. GREGORY: It could mean more than  
11 one store, Mr. Holland.

12 MR. HOLLAND: Yes, that is true too.

13 MR. RICHARDSON: Sir, if I may, an  
14 example of this would be in a partnership, where two  
15 partners are both pharmacists. Legally one is the  
16 manager, but actually both have dual responsibilities  
17 in the operation of a partnership like that.

18 MR. WHITELEY: The construction of the  
19 paragraph is that many require or have two or even  
20 three managers, and I was wondering why the indivi-  
21 dual store would require more than a single manager.

22 MR. HOLLAND: I can recall several  
23 businesses, or dispensaries, where there are two  
24 partners or owner-managers, but just at the moment  
25 I cannot recall whether there are a greater number  
26 than two. There may be in some instances.

27 MR. WHITELEY: Perhaps no one there  
28 can throw any light on that, but it struck me as  
29  
30



1 somewhat unusual for this scale of operation.

2  
3 At the foot of page 26 the statement  
4 is: "The largest net profit, both in actual dollars  
5 and as a per cent-of gross sales, was realised by  
6 those stores doing the greatest dollar volume of  
7 business". I was wondering whether an inference  
8 could be drawn from that statement that there is  
9 some reduction in cost according to the scale of  
10 operations, and that therefore one might expect  
11 that those doing the larger volume could supply  
12 prescriptions at a lower cost than those doing busi-  
13 ness at a lower volume?

14 MR. HOLLAND: I don't know the actual  
15 turnover that would be considered a profitable turn-  
16 over in a business, but certainly there are savings  
17 in some parts of a large operation. That is that  
18 delivery service might not necessarily be any more  
19 than for the smaller places. There would be some  
20 saving.

21  
22 MR. WHITELEY: The Commission has not  
23 received any indication that the prices of prescrip-  
24 tions tended to vary with the scale of operations  
25 of the dispensary, and I was wondering why that  
26 development hadn't occurred in the retailing of  
27 drugs.

28 MR. ANDERSON: May I direct the gentle-  
29 men's attention to Table 9, immediately following  
30 page 26. There is the detailed breakdown for this,



1 and I think you will notice the prescription receipts  
2 for the stores gross sales volume under \$50,000 was  
3 29.1%; \$50,000 to \$100,000 was 23.1%; \$100,000 to  
4 \$150,000 was 20.1%; and \$150,000 up was 27.0%. The  
5 average for all stores being 24.30%. You will also  
6 notice in this same table, average price per pres-  
7 cription filled in stores doing \$50,000 and less, the  
8 average price was \$2.24. In the stores doing  
9 \$150,000 and up, the average prescription price was  
10 \$3.14.  
11

12 MR. WHITELEY: Yes, but that is the  
13 reverse of the possibility I was suggesting.

14 MR. ANDERSON: Yes.

15 MR. WHITELEY: Which makes it even  
16 more of a question.

17 MR. ANDERSON: Those were the actual  
18 figures sent in to us, sir.

19 MR. WHITELEY: Yes, that is the ques-  
20 tion I am raising. The lower cost through the large  
21 volume stores is not reflected in the lowering of  
22 the prescription prices to the consumer.

23 MR. ANDERSON: No, it was not reflected  
24 in this review.

25 DR. MURRAY: There may be an explana-  
26 tion at the top of page 28: "It is of interest to  
27 note that these stores filled more prescriptions at  
28 a higher average prescription price than any other  
29 class of store, devoted a greater proportion of the  
30





1 floor area to the dispensary than any other class,  
2 and remained opened for business 16 hours longer  
3 per week than did the average of all stores reporting".  
4 The part I am drawing your attention to is: "Devoted  
5 a greater proportion of the floor area to the dispen-  
6 sary than any other class, and remained open for  
7 business 16 hours longer per week than did the average  
8 of all stores reporting".  
9

10 MR. WHITELEY: Yes, but that does not  
11 throw any light on my question. It may throw light  
12 on why your profits are larger.

13 DR. MURRAY: It might be significant  
14 then from Table 9 on page 27 when we were considering  
15 statistics, there were 22 stores reported in the  
16 first group, under \$50,000; 61 stores between  
17 \$50,000 and \$100,000; 26 in the next category; and  
18 only 5 in the fourth category, so from the statis-  
19 tical standpoint, or sampling of the population,  
20 they are really very small in this group, so maybe  
21 the figures are not as significant when you have a  
22 larger percentage.

23  
24 MR. WHITELEY: There is nothing in  
25 the report to indicate the representativeness of  
26 the reported stores.

27 I wonder if any light can be thrown  
28 on Tables 10 and 11, at pages 30 and 31, in relation  
29 to the stores having \$100,000 to \$150,000 volume.  
30 Table 10 shows total income of 16% for partnerships



1 and incorporated companies, whereas Table 11 for  
2 the sole proprietorships shows 12.4%. In other  
3 words, the partnerships and incorporated companies  
4 seem to be much more profitable than the sole  
5 proprietorships in the same size group.  
6

7 MR. GREGORY: Mr. Chairman, I have  
8 been informed that Mr. Merrett, who was here yester-  
9 day with the Province, prepared a good deal of the  
10 tabular matter in this report, and I don't know if  
11 we would be able to reach him by telephone and ask  
12 him to come over and assist us to the extent that he  
13 can.

14 MR. WHITELEY: I am sure he will know  
15 the figures, but unless he is familiar with the opera-  
16 tion he couldn't help us with the reason why these  
17 figures appear.

18 THE CHAIRMAN: What Mr. Whiteley wants  
19 to know is whether any of you could tell us if there  
20 is any significance attached to that distinction in  
21 the rate of profit, as between the partnerships and  
22 incorporated stores on the one hand and the sole  
23 proprietorships on the other. Whether you can tell  
24 us why there is such a marked difference in their  
25 profitability. As appears from the tables. It is  
26 an explanation of it, not merely an ascertainment of  
27 the facts that are here, but an explanation of what  
28 it means, what brings about that difference. If  
29 you haven't the information, of course we cannot get  
30



1 it from you.

2 MR. GREGORY: I think, Mr. Chairman,  
3 that the gentlemen present could only speculate.

4 THE CHAIRMAN: I think if they knew  
5 the answer they would probably have told us.

6 Mr. MacLeod, you haven't anything  
7 further?

8 MR. MACLEOD: No, sir.

9 THE CHAIRMAN: Mr. Gregory, have you  
10 anything you wish to add?

11 MR. GREGORY: No, Mr. Chairman.

12 THE CHAIRMAN: As far as the Commis-  
13 sion is concerned, I think we have asked all the  
14 questions available to us.

15 Thank you, gentlemen, for giving us  
16 your time.

17 We will adjourn now.

18  
19  
20 --- The hearing adjourned at 12.45 p.m.





